Brighton & Hove City Council

Overview & Scrutiny Committee

Title:	**Health Overview & Scrutiny Committee**
Date:	**19 October 2016**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall, Norton Road, Hove, BN3 4AH**
Members:	**Councillors: Simson (Chair), Allen, Bennett, Cattell, Deane, Knight, Marsh, O'Quinn, Peltzer Dunn, Taylor** **Co-opted Members: Colin Vincent (Older People's Council), Fran McCabe (Healthwatch), Caroline Ridley (Community & Voluntary Sector)**
Contact:	**Giles Rossington** Senior Scrutiny Officer 01273 29-1038 giles.rossington@brighton-hove.gov.uk

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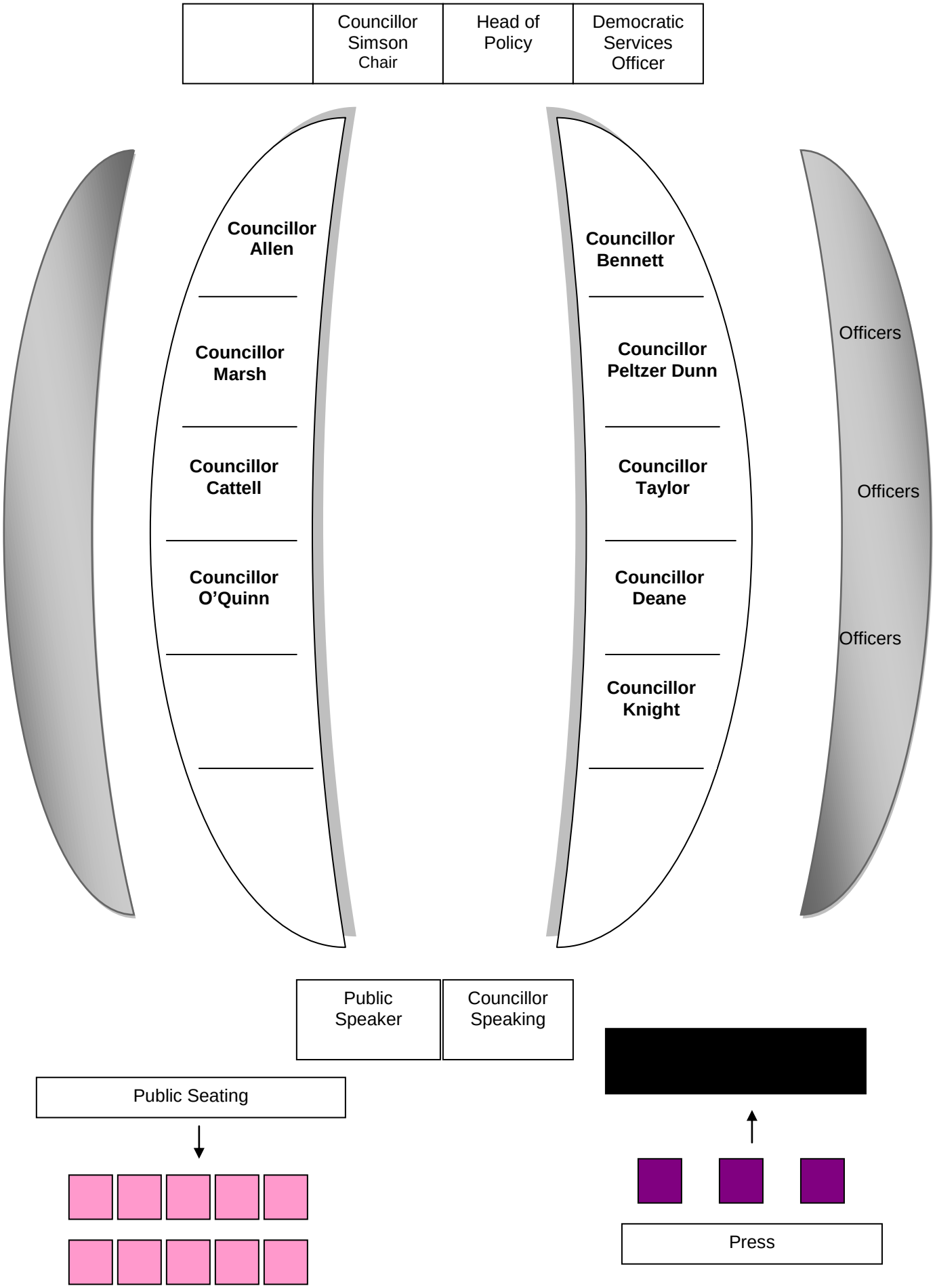
Democratic Services: Overview & Scrutiny Committee



AGENDA

PART ONE **Page**

27 APOLOGIES AND DECLARATIONS OF INTEREST

28 MINUTES

To consider the minutes of the last scheduled meeting held on 20 July 2016, and of the special meeting held on 05 October 2016 (to follow for committee meeting)

29 CHAIRS COMMUNICATIONS

30 PUBLIC INVOLVEMENT **1 - 4**

To consider the following matters raised by members of the public:

(a) **Petitions:** to receive any petitions presented by members of the public to the full council or at the meeting itself;
(b) **Written Questions:** to receive any questions submitted by the due date of 12 noon on the 14th October 2016.
(c) **Deputations:** to receive any deputations submitted by the due date of 12 noon on the 14th October 2016.

A deputation was referred to the HOSC from July 2016 Full Council. A response to this deputation will be provided at the committee meeting.

31 MEMBER INVOLVEMENT

To consider the following matters raised by councillors:

(a) **Petitions:** to receive any petitions submitted to the full Council or at the meeting itself;
(b) **Written Questions:** to consider any written questions;
(c) **Letters:** to consider any letters;
(d) **Notices of Motion:** to consider any Notices of Motion referred from Council or submitted directly to the Committee.

32 REGIONAL REVIEW OF STROKE SERVICES: UPDATE **5 - 20**

Report of the Executive Lead, Strategy, Governance & Law, on NHS plans to reconfigure Sussex stroke services.

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards*

33 SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST: CQC INSPECTION REPORT **21 - 64**

Report of The Executive Lead Strategy, Governance and Law, on the recent CQC inspection of SECAmb.

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards*

34 PATIENT TRANSPORT SERVICES (PTS): UPDATE **65 - 110**

Report of the Executive Lead, Strategy, Governance & Law, on Sussex Patient Transport Services (PTS).

Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards*

35 HOSC DRAFT WORK PLAN/SCRUTINY UPDATE **111 - 114**

The latest version of the HOSC 2016/17 work plan is included for information (copy attached)

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions and deputations to committees and details of how questions and deputations can be raised can be found on the website and/or on agendas for the meetings.

The closing date for receipt of public questions and deputations for the next meeting is 12 noon on the fifth working day before the meeting.

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Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

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For further details and general enquiries about this meeting contact Giles Rossington, (01273 29-1038, email giles.rossington@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

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OVERVIEW & SCRUTINY COMMITTEE

Please inform staff on Reception of this affects you so that you can be directed to the Council Chamber where you can watch the meeting or if you need to take part in the proceedings e.g. because you have submitted a public question.
Date of Publication – 11 October 2016

Deputation concerning proposed Sustainability and Transformation Plan
Spokesperson – Madeleine Dickens

Summary of financial arrangements imposed by NHS England

- Comparisons of percentages of GDP spent on health and social care.
- Although the government fulfilled its NHS funding commitment – with funding increasing by an average of 0.8 per cent per year in real terms – the increases delivered were less than the estimated growth of 3 to 4 per cent per year required to meet higher costs of new medical technologies and increases in demand for health care. Over the same period local government has seen a real reduction in spending on adult social care of 12%.
- Sustainability and transformation fund – the fallacy
- All but one of the 44 STPs is in deficit overall, according to research carried out by the HSJ, and about a third have deficits of more than 4% of their turnover. The STP must show how local services will become sustainable over the next five years. It must set out initiatives to manage demand, increase provider efficiency, reconfigure services and, the most important of all, balance the budget in the local area.
- The Kings Fund has said "It is inconceivable that the NHS will be able to achieve both financial sustainability and large-scale transformation within these financial constraints."

Equalities impact, democracy and STP

STP was imposed and draft plans submitted on the 30th June with no parliamentary oversight or mandate, no consultation, and by their own admission - no legal status.
There is already a rapidly growing equality gap in the health and social care economy – successive cuts and privatisation taking their toll on local services. The Public health department budget has reduced by 18%, projected to rise to 25% by 2020, since its re-creation under the Health and Social Care Act. Major services have gone out to non LA contractors, Children's and young people's services currently out to tender. At the same time, 9 GP practices across the city have closed (with more closures looming)….list of further services affected. These developments inevitably have the biggest impact on the most vulnerable and those most in need living in the most deprived neighbourhoods. With the level of savings necessary to balance the STP budget this equality "gap" can only widen further.

Local Democracy

To break even STP Boards are going to have to implement massive change – the selling-off of NHS estate and land, workforce reductions, the even greater influx of private companies, with serious implications for local communities and the local economy. Yet in April the LGA no less highlighted the democratic deficit underlying STP, criticising -
"Pace of implementation undermining local ownership and squeezing out LA and community involvement.
Lack of democratic accountability, eroding the role of HWBs
Footprints over-ride devolution or local govt transformation boundaries.
Angry concern is being expressed by some HWBs and other bodies about STP.

Requested action

- This submission be referred to the OSC to request a copy of the draft STPlan, gather evidence on its implications and to make recommendations to full council.
- The full council recommends that the HWB call public consultation meetings on STP at the earliest opportunity.
- The council look at the best means of soliciting the opinion of city residents on the tendering out of local NHS services along the lines of the University of Brighton Citizens' Health services survey examining attitudes to privatisation.

Background paper - NHS Funding and NHS England's Sustainability and Transformation Plans

1. The UK currently spends 8.8% of its GDP on health services. This compares with an OECD average of 8.9%, Greece spends 9.1%, France 10.9%, Germany 11%, and the big spender US 16.4%. It is true that of that proportion of UK's GDP most is public funding, but this is also the case with all other countries. So don't let's get carried away with the idea that we are big spenders on health – **we're not.** In fact under government's plans the GDP proportion spent on the UK's health is set to fall to 6.7% by 2021. **This will make us one of the lowest health spenders in the world.**

2. In 2015 the politically neutral Kings Fund said of the Coalition government
   Although the government fulfilled its NHS funding commitment – with funding increasing by an average of 0.8 per cent per year in real terms – the increases it delivered were less than the estimated growth of 3 to 4 per cent per year required to meet higher costs of new medical technologies and increases in demand for health care. Over the same period local government has seen a **real reduction in spending on adult social care of 12 per cent**. (1)
   So, to meet increasing demand the NHS requires a 3-4% budget increase, and it got 0.8% while at the same time adult social care had 12% reductions in its budget. This resulted in most hospital trusts falling into colossal deficits (2) of £2.8 billion, to pay for bills, staff wages, energy bills and drugs; unprecedented in the history of the health service.

3. The STP (3) must show how local services will become sustainable over the next five years. It must set out initiatives to manage demand, increase provider efficiency, reconfigure services and, the most important of all, balance the budget in the local area.

4. So NHS England is demanding that trusts must absorb the deficit, accumulated because of underfunding through the Coalition years, in their plans for the next five years and prove that they balance the books. So trusts ability to meet the demands for services in the next 5 years will be hampered by having to absorb the previous 5 years' deficit.

5. There is funding available for the STPs, known as the **Sustainability and Transformation Fund (STF)**. This fund is held by NHS England, but it is ring-fenced and can only be released with agreement from both the Department of

Health and HM Treasury. The fund is released quarterly, in arrears, to the organisations in the STP footprint.

6. Other funding available for transformation is held by NHS England and this has been added to the pot (amounting to £339 million in 2016/17), creating a total Sustainability and Transformation Fund of £2.1 billion for 2016/17. The fund grows to reach £3.4 billion by 2020/21.
7. The catch is that none of this funding is available unless the STP footprint can show that it is able to balance its books. For 2016/17 the providers (NHS trusts) must show they are cutting their deficits and demonstrate that the plan leads to staying within their budget for 2016/17. The STP must then work to keep the footprint within its budget for the next four years in order to qualify for further funding from the STF.

8. The STPs bring together NHS trusts that are in a very difficult position financially, with almost all of them in deficit, with other organisations, including CCGs, most of which are not in deficit, although not flush with money either. The result is that the overall financial situation of the STP footprints is very poor; all but one of the 44 STPs is in deficit overall, according to research carried out by the HSJ, and about a third have deficits of more than 4% of their turnover.

9. *Anita Charlesworth, chief economist at the Health Foundation, has noted that, " turning that sort of financial performance around when there are so many other underlying issues is an enormous if not impossible task."*
   The normally cautious Kings Fund has said "It is inconceivable that the NHS will be able to achieve both financial sustainability and large-scale transformation within these financial constraints." (4)

10. The first tranche of money from the £2.1 billion STF for 2016/17 has already been allocated to NHS trusts, however due to the dire finances of the trusts, all £1.8 billion will be spent on bailing out the providers' deficits.

11. The government through NHS England is therefore set to limit the range of services provided, downgrade the quality of remaining services, more often than not provided by private profit-seeking companies, with reductions in staffing levels involving even lower morale with industrial disputes on an unprecedented level. What we are witnessing is the contraction of a health service from one driven by patient need and heralded by the Commonwealth Fund as the best in the world (5), to one controlled primarily by impossible financial targets.

References

1. http://www.kingsfund.org.uk/projects/verdict/nhs-heading-financial-crisis
2. https://www.theguardian.com/society/2016/jul/17/nhs-hospitals-borrowed-record-28bn-from-government-last-year
3. https://www.england.nhs.uk/2015/12/long-term-approach/
4. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Planning-guidance-briefing-Kings-Fund-February-2016.pdf

5. http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf
6. http://www.oecd.org/unitedkingdom/Country-Note-UNITED%20KINGDOM-OECD-Health-Statistics-2015.pdf

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 32 Brighton & Hove City Council

Subject:		**Sussex-wide Review of Stroke Services**
Date of Meeting:		**19 October 2016**
Report of:		**Executive Lead for Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-5514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 There is an ongoing Sussex-wide review of stroke services. The HOSC was presented with an update on this work at the February 2016 Overview & Scrutiny Committee (OSC) meeting.

1.2 This report provides a further update on the work of the review, focusing on plans to reconfigure stroke services across the Brighton & Sussex University Hospitals Trust (BSUH) 'footprint' – i.e. for residents of Mid Sussex and Brighton & Hove.

2. RECOMMENDATIONS:

2.1 That members note the evidence provided detailing the benefits and risks of the Central Sussex Stroke Programme Board's recommendation to centralise Hyper Acute Stroke services and Acute Stroke services at the Royal Sussex County Hospital (RSCH), Brighton (**Appendix 1**).

2.2 That members agree that the HOSC should continue to receive updates on the progress of the stroke review, but that no further formal consultation with the HOSC is required.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The Sussex-wide review of stroke services aims to improve clinical outcomes for people in Sussex who suffer a stroke. Key to improving outcomes is ensuring that patients receive treatment in the most appropriate clinical environment. There is a growing body of evidence indicating that the best outcomes are achieved when patients are treated in specialist centres rather than having all District General Hospitals in an area provide the whole range of stroke services.

3.2 Currently, stroke services for residents of Brighton & Hove, High Weald Lewes Havens and Mid Sussex are provided at both the Royal Sussex County Hospital, Brighton (RSCH), and the Princess Royal Hospital, Hayward's Heath (PRH). The plan is to single-site the bulk of stroke services for the BSUH 'footprint' at the

RSCH. **Appendix 1** includes more information on these plans provided by NHS commissioners.

3.3 Where HOSCs identify local NHS reconfiguration plans as constituting a "substantial variation" of services, they may require NHS bodies to consult formally with them before implementing their plans. HOSCs are not obliged to insist on a process of formal consultation, even if they do consider plans to be substantial – for example where HOSC members feel that a planned change is clearly in the best interest of local residents.

3.4 The stroke review update (**Appendix 1**) sets out a compelling clinical argument for the single-siting of local stroke services at the RSCH. Since city residents already access stroke services at the RSCH, there would be no detrimental impact to local people in terms of additional travel for families etc. Given that the impact of these changes on Brighton & Hove is therefore likely to be positive rather than negative, it is advised that the HOSC does not require formal consultation on this matter. However, members will be well aware of serious issues with capacity at the RSCH, and before agreeing not to require formal consultation, the HOSC may wish to be assured that BSUH is able to manage this additional workload. Should HOSC members not feel assured that this is the case, then they may wish to enter into more formal consultation on the stroke review plans.

3.5 This issue also affects residents in West Sussex, and to a lesser extent East Sussex, and is therefore being considered by West Sussex HASC and by East Sussex HOSC. Should two or more HOSCs require more formal consultation then this may well be via a formal Joint HOSC (JHOSC).

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Members have the option to require additional consultation with the HOSC on plans to reconfigure stroke services. As the clinical case for single-siting is compelling, and as RSCH is a more obvious candidate as a site for specialist services than PRH, it is unclear what value would be added for Brighton & Hove residents by further scrutiny – always assuming that BSUH can take on the extra work-load without an adverse impact on its other services. In consequence, the recommendation is for the HOSC not to require more formal consultation.

4.2 However, if members are not assured that the single-siting of stroke services can be achieved without a negative impact on other RSCH services, or are not persuaded by other aspects of the reconfiguration plans, they have the option to require further consultation. This may well need to involve joint working with West Sussex HASC and/or East Sussex HOSC.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None in relation to this report.

6. CONCLUSION

6.1 There is a compelling case for the single-siting of BSUH 'footprint' stroke services, and for the single-site to be at the RSCH, provided that the additional capacity can be found at RSCH without detriment to other local services.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None identified.

Legal Implications:

7.2 There are no legal implications arising from this report.

Lawyer Consulted: Elizabeth Culbert; Date: 27/09/16

Equalities Implications:

7.3 None directly. The proposed reconfiguration would not adversely impact city residents, including protected groups, who would continue to access services at RSCH.

Sustainability Implications:

7.4 City residents would continue to access services at RSCH, although there would be more journeys into and from the city as patients formerly treated at PRH would now be diverted to RSCH.

Any Other Significant Implications:

7.5 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. Information on the Sussex stroke review provided by NHS commissioners.

Documents in Members' Rooms

None

Background Documents

None

Appendix 1

*Any of the implications listed below can be included in the body of the report under the heading **Any Other Significant Implications** and especially where they have a significance that should be drawn to Members' attention. Otherwise list them here in appendix 1 or state that there are '**None'** under the heading in the report and delete this appendix and upload any relevant appendices to the report.*

Crime & Disorder Implications:

[Consider the effect of the proposals on the council's duty to prevent crime and disorder].

1.1

Risk and Opportunity Management Implications:

[Set out how risks and opportunities have been assessed and details of any risk management actions planned]. Contact: jackie.algar@brighton-hove.gov.uk

1.2

Public Health Implications:

[This section should reflect the council's commitment to improve Public Health and Wellbeing and to Reduce Inequalities across the city - health, equalities & wellbeing tool kit is available to help report writers complete this section].

There are naturally some overlaps with the Equalities and Sustainability sections. Consider the effect of the proposals on the council's duty to promote the public health and wellbeing of people in its area.

1.3

Corporate / Citywide Implications:

[Set out how the proposals support the council's priorities and their effect on other services, other agencies and the city as a whole].

1.4

Subject:	**Central Sussex Stroke Services Review briefing**
To:	**All members of the Brighton and Hove Health Overview & Scrutiny Committee**
From:	**Central Sussex Stroke Programme Board**
Authors:	Caroline Huff, Central Sussex and East Surrey Alliance Clinical Programme Director
Date:	30-09-2016
Key points	This report includes a summary of: • The clinical engagement completed • Brighton and Hove CCG Governing Body response • BSUH Staff response • Quality of the service data • Any further patient and family engagement and BSUH mitigating actions • Response from affected partner organisations (county councils and SECAMB)

1. Background

The NHS Five Year Forward View, published in October 2014 by NHS England, identified that for some services, such as stroke, there is a compelling case for greater concentration of care. More specifically it highlights the strong relationship between the number of patients and the quality of care, derived from the greater experience these more practised clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. The document specifically highlights the London service change of consolidating 32 stroke units into eight hyperacute units (units where patients are cared for for the first three days) and a further 24 units providing care after the first 72 hours, and highlights that this has achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.(NHSE, 2016).

There is also a compelling economic argument for reducing the number and severity of strokes. A study by Youman et al. (2003) identified that for every patient who experiences a stroke, the cost to the NHS in the UK is £15,306 over 5 years and, when informal care costs are included, the amount increases to £29,405 (2001/2002 prices).

2. Clinical engagement

2.1 The Central Sussex Stroke Programme Board for High Weald Lewes Havens CCG, Brighton and Hove CCG and Horsham and Mid Sussex CCG have been working together, in collaboration with their neighbouring CCGs, Trusts and County Councils, to complete that detailed options appraisal. The Group has been chaired by the Stroke GP Lead for HMS CCG. Membership includes over 30:

- Senior Clinicians and Managers from the CCGs (Brighton and Hove CCG, High Weald Lewes Havens CCG, Horsham and Mid Sussex CCG and Crawley CCG and Coastal West Sussex CCG),
- Acute Trusts (Brighton and Sussex University Hospitals NHS Trust, East Sussex Healthcare Trust and Surrey and Sussex Healthcare Trust),
- The South East Coast Ambulance Service,
- Sussex Community NHS Foundation Trust, Sussex Partnership Foundation Trust,
- Councils (West Sussex County Council, Brighton and Hove City Council and East Sussex County Council),
- 2 lay members and the South East Clinical Network.

This Group has agreed that their preferred option is to have a joint Hyper Acute Stroke Unit/Acute Stroke Unit at the RSCH only at BSUH and no longer have a stroke in-patient service at PRH.

2.2 During August and September, the CCG Clinical Executive Groups and some of the GP locality groups have considered the Central Sussex Stroke review. These groups included 24 GPs and senior Clinicians (10 from BH CCG, 8 from HWLH CCG and 6 from HMS CCG) and agreed that clinically, the preferred option was the

correct thing to do to improve the care for stroke patients. They raised a number of questions for assurance, which have been responded to by Dr Nicky Gainsborough, BSUH Stroke Consultant. These included:

- There has been minimal impact on other patients at RSCH and on critical care from the temporary divert. Since February 2016, the Trust and CCGs agreed to temporarily not treat stroke patients at PRH as the specialist stroke staffing levels were inadequate due to several staff leaving and not being able to recruit replacement staff.
- The pre alert call to the Stroke Specialist Team has not been hampered by ambulances queuing outside the emergency department (ED) throughout the temporary divert and patients are received quickly and efficiently by the stroke specialist team who meet the ambulance at the A/E Front door
- There have not been an increase in "Delayed Transfers of Care" on the system due to the divert, but Length of Stay at RSCH for Stroke patients will have increased due to pressures on social care in the West and East.
- Work is underway across Sussex to increase access to Early Supported Discharge/responsive services and 6 month reviews.
- 7 day-a-week services will deliver better outcomes, less disability and lower Length of Stay**.**

2.3 GPs in Horsham and Mid Sussex, High Weald Lewes Havens and Brighton and Hove CCG areas received a written update on the stroke review during August 2016 and the CCG GP clinical leads for stroke have been discussing the review and recommended option at meetings with their GP colleagues.

2.4 HMS CCG Governing Body discussed the review and preferred option at their Governing Body meeting on 06/09/2016 where there was broad agreement with the proposed reconfiguration plans. Brighton and Hove CCG Governing Body was on 27/09/2016 and they confirmed there was support from clinicians on the Governing Body around the model of care and the better outcomes for patient. They have delegated the final agreement to the BH CCG Clinical Strategy meeting on 11/10/2016 as the CCG wanted reassurances or mitigation that other acute trusts in the footprint would provide support if needed. This was to enable reassurance to be received about mitigation which could be needed if there were any further increases in admissions of stroke patients from West Sussex to the RSCH. However, CWS CCG confirmed at the WS HASC on 29/09/2016 that there are no plans in the short term (within the next 3 years) to make any changes to their 2 site service at WSHT. High Weald Lewes Havens CCG Governing Body was on 27/09/2016 and they agreed to support the preferred option.

2.5 At the Central Sussex Stroke Programme Board on 01/09/2016, the BSUH Service Strategy Director confirmed that Staff affected are generally positive about the change. BSUH has actively engaged staff to date in discussing the potential changes to stroke services. As we move closer towards a decision regarding reconfiguration, BSUH will establish monthly meetings to ensure that staff are fully informed and able to input into the process. The changes proposed may lead to staff members roles being affected. The Trust will ensure that there is appropriate staff consultation in these circumstances, which will include negotiation on any mitigating actions which the Trust will consider.

2.6 The mobilisation plan drafted by the Trust estimates that, once consultation is complete and the funding confirmed, the Trust will need a minimum of 12 months to implement. This allows 3 months for Board approval and staff consultation, a further 6 months to advertise, appoint and have staff in place, and a further 3 months to induct and train staff.

2.7 At the WS HASC ON 29/09/2016, it was decided that the case was strong for improved quality and outcomes for the preferred option and, therefore, did not believe this was a substantial change requiring formal consultation. At the ES HOSC, held simultaneously, it was agreed that they did consider the change to substantial requiring formal public consultation, which should be 'proportionate and targeted' to those most likely to be affected.

3. Impact on patients and their families of the preferred option

3.1 At the Central Sussex Stroke Programme Board on 01/09/2016, East Sussex Healthcare NHS Trust (ESHT) confirmed that since they centralised services onto the Eastbourne site in 2012, the standard of care received by patients has improved across all domains.

3.2 Evidence from the national Stroke audit (SNAPP) shows excellent standards of care at the RSCH which are now being experienced by all stroke patients. These include:

- Shorter time to Consultant review
  - 97% seen < 24 hours (nationally 79.1%)
  - Average time to review of 4h 27min (nationally 12h 3min)

- CT scan in less than 1 hour
  - 71.1% of patients (nationally 48.4%)
  - Average wait for scan of 34 minutes, (nationally 3h 51min)
- This leads to higher thrombolysis rate
  - 14.8% (nationally 11.4%)
- Shorter time to Specialist Nurse review
  - 94.1% < 24 hours (nationally 89%)
  - Average time to review of 13 minutes (nationally 1h 30min)
- Higher number of initial swallow assessments
  - 95.8% (nationally 71.2%)
- All patients receive nutrition screen and dietician review
  - 100% (nationally 90.2%)
- Higher rates of mood and cognition screening by discharge
  - 97.5% (nationally 89.2%)
- Continence plan in less than 3 weeks
  - 93% (nationally 89.7%)
- Consultant delivered ward rounds at Royal Sussex County Hospital 7 days a week

3.3 The changes will allow for a range of quality improvements, many of which are set out in the options appraisal. Centralising services with fully staffed Hyper Acute Stroke Unit will improve a range of SSNAP standards, including

- Admission direct to a stroke ward
- Time to thrombolysis, especially out of ours
- Improved Occupational Therapy services
- Improved Physiotherapy services
- Improved Speech and Language services

3.4 At the Central Sussex Stroke Programme Board on 01/09/2016, the Group reviewed the Equality Impact Assessment of the proposed changes to ensure they have considered the potential impact on all people with 'protected characteristics' including:

- Ensuring early supported discharge service is in place,
- Preparing information for carers on transport into Brighton, and parking facilities at RSCH and nearby.
- Ensure appointment times take account of distance required to travel (e.g. ensure they are not first thing in the morning)
- Reviewing HASU/ASU visiting times to give more flexibility for carers; ensure carers are provided with information about ward routines as a matter of course. An ASU is a stroke unit for 4-10 days after admission. At RSCH the HASU and ASU are combined.

Equality Group	Specific Action	Monitoring Arrangements
Age	Ensure access to early supported discharge is available. Ensure discharge support services are in place in both areas.	The CCGs are working with Sussex Community Foundation Trust to outline the timeframes for re-organising community responsive/Early Supported Discharge services for patients being discharged from BSUH.
Deaf patients and those with overseas language support needs	Ensure information on interpreting services are available to all staff, and that all staff are aware of the need for trained interpreters in preference to reliance on family members	We have a translation service that we can access
Carers	Develop a carers' information pack as a co design process with local carers' support organisations. Ensure information is appropriate to the selected option	Carers bi monthly meeting to support and review information. Comprehensive information given to patient/carer on discharge
Gender reassignment	Ensure staff have appropriate training/awareness in order to support trans patients and carers appropriately	Current monitored rate 68% trained

3.5 - During August and September 2016, the Crawley, Horsham and Mid Sussex, High Weald Lewes Havens and Brighton and Hove CCGs sent updates on the stroke review and its outcomes to 19 patient and public groups

who were involved in the previous engagement, such as stroke groups and clubs for stroke patients and carers. In these communications, the programme board has reiterated its commitment to further patient and public engagement, if advised to do so by the health scrutiny committees of West Sussex and East Sussex County Councils and Brighton & Hove City Council
before final decisions are made.

3.6 Privacy Impact Assessment-BSUH believe that there are no impacts regarding privacy relating to this proposal.

4 Feedback from affected local services

4.1 South East Coast Ambulance (SECAMB) Service

At the Central Sussex Stroke Programme Board on 1st September 2016, SECAMB confirmed that of the options put forward, Option 6 (HASU/ASU at RSCH) represents the best possible option, based on the following factors:

i. Locating the services at RSCH will lead to lower average inbound ambulance travel times for the majority of the patient population BSUH serves (compared to locating the services at PRH), maximising the likelihood of timely access to definitive care
ii. SECAmb welcomes the reduction in complexity that locating all services in a single site with 24/7 access brings. This will make clinical decision-making simpler and improve safety for patients.
iii. Since February 2016, a temporary stroke service divert has been in place due to non-availability of specialist staff to support the stroke service at the PRH site. This has led to patients who would otherwise be taken to PRH being conveyed to RSCH, and (in small numbers) to East Surrey hospital. To date, there have been no adverse incidents or complaints associated with this change that SECAmb is aware of. This provides some further reassurance as to the viability of this option.
iv. The maximum increase in journey times is approximately 35 minutes, based on expected travel times from the geographical centre of each electoral ward to PRH and alternative hospital sites where stroke services are provided. The maximum travel inbound travel time remains under 45 minutes for patients in all electoral wards affected by this proposed change.
v. SECAmb's standard practice is to pre-alert hospitals to enable them to prepare to receive patients with complex needs such as potential strokes, traumatic injury etc. This enables a fast handover to the hospital's specialist team and thereby minimises the time from the initial 999 call to receiving definitive treatment and care.
vi. However, increased travel times increase the overall job cycle time, reducing the level of resource available to respond to other incidents. It was agreed that this would be given due consideration in the CCG/SECAMB contracting discussions.

4.2 The table below shows average expected travel times from the geographical centre of each electoral ward for which PRH is the nearest hospital, and shows the increased journey time resulting from the need to travel to an alternative specialist site.

Electoral Ward	Patient Incidents	Nearest Hospital	Travel Time (current, hh:mm)	Next Nearest Hospital	Travel Time (new, hh:mm)	Patient journey time increase (hh:mm)
Haywards Heath Franklands	9	PRH	00:00	Royal Sussex County	00:31	00:31
Haywards Heath Bentswood	12	PRH	00:02	Royal Sussex County	00:35	00:33
Haywards Heath Ashenground	5	PRH	00:02	Royal Sussex County	00:33	00:31
Haywards Heath Heath	8	PRH	00:03	Royal Sussex County	00:34	00:31
Haywards Heath Lucastes	8	PRH	00:03	Royal Sussex County	00:31	00:28
Lindfield	9	PRH	00:04	Royal Sussex County	00:33	00:29
Cuckfield	4	PRH	00:08	East Surrey	00:30	00:22
Chailey and Wivelsfield	2	PRH	00:08	Royal Sussex County	00:29	00:21
Burgess Hill Franklands	7	PRH	00:10	Royal Sussex County	00:28	00:18
Burgess Hill Leylands	8	PRH	00:10	Royal Sussex County	00:28	00:18
Burgess Hill St. Andrews	5	PRH	00:11	Royal Sussex County	00:30	00:19
Burgess Hill Dunstall	3	PRH	00:11	Royal Sussex County	00:28	00:17
Burgess Hill Victoria	8	PRH	00:12	Royal Sussex County	00:25	00:13
Ditchling and Westmeston	5	PRH	00:12	Royal Sussex County	00:23	00:11
High Weald	6	PRH	00:13	East Surrey	00:34	00:21
Newick	4	PRH	00:13	Royal Sussex County	00:31	00:18
Bolney	0	PRH	00:13	Royal Sussex County	00:26	00:13
Burgess Hill Meeds	10	PRH	00:13	Royal Sussex County	00:24	00:11
Ardingly and Balcombe	6	PRH	00:14	East Surrey	00:24	00:10
Hassocks	18	PRH	00:14	Royal Sussex County	00:22	00:08
Danehill/Fletching/Nutley	5	PRH	00:15	Eastbourne	00:34	00:19
Plumpton, Streat, East Chiltingtor	0	PRH	00:16	Royal Sussex County	00:25	00:09
Hurstpierpoint and Downs	4	PRH	00:16	Royal Sussex County	00:19	00:03
Barcombe and Hamsey	0	PRH	00:18	Royal Sussex County	00:23	00:05
Uckfield North	3	PRH	00:20	Eastbourne	00:34	00:14
Cowfold, Shermanbury and West	4	PRH	00:20	Worthing	00:30	00:10
Nuthurst	2	PRH	00:20	East Surrey	00:30	00:10
Uckfield Central	3	PRH	00:21	Royal Sussex County	00:32	00:11
Broadfield South	0	PRH	00:21	East Surrey	00:22	00:01
Uckfield New Town	3	PRH	00:22	Eastbourne	00:31	00:09
Tilgate	0	PRH	00:22	East Surrey	00:24	00:02
Henfield	9	PRH	00:22	Worthing	00:24	00:02
Crawley Down and Turners Hill	1	PRH	00:22	Princess Royal	00:22	00:00
Uckfield Ridgewood	1	PRH	00:23	Royal Sussex County	00:27	00:04
Broadfield North	0	PRH	00:23	East Surrey	00:24	00:01
Rusper and Colgate	0	PRH	00:23	East Surrey	00:24	00:01
Buxted and Maresfield	6	PRH	00:24	Royal Sussex County	00:38	00:14
Bewbush	0	PRH	00:24	Princess Royal	00:24	00:00
East Grinstead Herontye	0	PRH	00:25	East Surrey	00:28	00:03
Hartfield	3	PRH	00:26	East Surrey	00:38	00:12
Southwater	4	PRH	00:26	Worthing	00:36	00:10
Forest	1	PRH	00:26	East Surrey	00:33	00:07
Horsham Park	1	PRH	00:26	East Surrey	00:33	00:07
Ashurst Wood	0	PRH	00:26	East Surrey	00:30	00:04
Forest Row	1	PRH	00:27	East Surrey	00:32	00:05
Holbrook West	0	PRH	00:27	East Surrey	00:28	00:01
Roffey South	2	PRH	00:27	East Surrey	00:28	00:01
Crowborough St. Johns	0	PRH	00:28	Royal Sussex County	00:42	00:14
Denne	4	PRH	00:28	East Surrey	00:36	00:08
Roffey North	2	PRH	00:28	East Surrey	00:29	00:01
Crowborough West	0	PRH	00:29	Royal Sussex County	00:42	00:13
Trafalgar	0	PRH	00:29	East Surrey	00:34	00:05
Holbrook East	0	PRH	00:29	East Surrey	00:30	00:01
East Grinstead Ashplats	2	PRH	00:29	East Surrey	00:30	00:01
Itchingfield, Slinfold and Warnhar	4	PRH	00:31	East Surrey	00:35	00:04
Broadbridge Heath	3	PRH	00:31	East Surrey	00:35	00:04
Crowborough East	0	PRH	00:32	Eastbourne	00:42	00:10
Crowborough North	0	PRH	00:33	Eastbourne	00:44	00:11
Crowborough Jarvis Brook	0	PRH	00:34	Eastbourne	00:42	00:08
Rotherfield	1	PRH	00:34	Eastbourne	00:40	00:06
Frant/Withyham	0	PRH	00:37	Conquest	00:44	00:07

3.2 **Councils in Sussex**

3.2.1 **West Sussex County Council (Adult Social Care)**: The most important issue is what is best for patients and the County Council recognise that this will be achieved through delivering the service on a single site and the arguments for that service being at the RSCH rather than PRH. The County Council officers currently have some challenges when they assess patients at RSCH. They do not have IT access or office space. West Sussex Council (Adult Social Care) supports the BSUH preferred option 6 (HASU/ASU at RSCH only) but would want to Trust to address the issue of IT access, space and staffing resource.

3.2.2 **East Sussex County Council**: Single siting of the HASU and ASU and subsequent co-location of stroke patients would ensure that all ESCC/ASC provided services are able to offer timely and consistent support to stroke patients and their carers within a single pathway.

3.2.3 **Brighton and Hove City Council**: Option 6 enables more effective social work support and proactive discharge planning to be provided and developed as patients will remain on one site. This model means we are likely to see an increase in the proportion of patients that can be discharged home with support from community services and further reduce the proportion of stroke patients that are admitted to the Sussex Rehabilitation Centre (SRC) for ongoing specialist rehabilitation.

It was agreed at the Central Sussex Stroke Programme Board on 1st September that a meeting will be set up between the Trust, the County Councils and Sussex Community Foundation Trust to explore mitigating options to address the issues raised.

4. **Substantial service change or not?**

NHS bodies (and providers and commissioners of NHS services) have a statutory duty to consult local health scrutiny committees on any proposals they may have for any substantial development of or variation to the health service in the area. There is no definition of "substantial", and it is expected that NHS bodies and HOSCs will reach a local understanding. Below is the checklist used by West Sussex HASC to determine whether plans constitute a 'substantial variation'. It is included for information only. The aim of this checklist is to help the NHS bodies and the HASC with that decision. Where it is agreed that proposals are substantial, HASC will also discuss with the NHS what public consultation is required.

Theme	Characteristics suggesting that the service change:	
	a) Is substantial	**b) Is not substantial**
What are the reasons for the proposed change?		• It is not a permanent reduction or closure of service provision but the same service delivered on one site at BSUH instead of split across 2 sites • The service change is not primarily driven by financial or other managerial factors but staffing factors have been a driver with difficulties recruiting the specialist stroke staff on 2 sites. • The service change is being driven by and will improve patient experience/outcomes, improving clinical quality and reduce risk. • This is a service improvement and an enhancement of staff levels to meet the South East Clinical Network standards. • The change will improve the health and wellbeing outcomes for local people through faster treatment and comprehensive care. • It will improve patient experience and outcomes • It is currently a temporary change but the Central Sussex Stroke Programme Board has submitted centralising the services at RSCH as their preferred long-term solution.
How will the accessibility of services and how they are delivered change?	• Some patients and their families/carers(i.e. those who were an in-patient at PRH) will have further to travel to access the BSUH Stroke in-patient service. • Locating the HASU and ASU at	• Services are being relocated to improve patient experience and outcomes • All stroke patients will be co-located with other relevant health and social care services such as

	RSCH may bring some disadvantages due to the limited parking facilities available at RSCH, which may present challenges in accessing the site for patients and visitors. However, public transport links to RSCH are good, with regular bus services stopping directly outside the hospital, and regular mainline train services into Brighton from London and the South Coast. There is also a current bus service running between PRH and RSCH, which is available for public use. In the longer term, the 3Ts hospital development is expected to alleviate some of the current pressures of parking, however other options to mitigate these access problems are being explored in the short to medium term by BSUH	Interventional Radiology and the Trauma Centre
How will patients be affected?	• Patient choice of being taken by ambulance to a dedicated stroke unit as an emergency will remain. Patient choice of receiving their acute stroke care in a hospital nearer home (i.e. PRH) is reduced, but they will be benefitting from a better rehabilitation service for all patients on the single site.	• 23.4% of the BSUH current patients will be affected by the service change. However, 39% of patients who have a stroke in West Sussex are treated at PRH
Will there be any impact on the wider community and other services?	• Increased travel by families will have a negative impact on the environment of the locality • Rural areas will be more affected than those in the urban area of Brighton.	• There will be a positive impact on the economy through reducing longer-term consequences of a stroke. • Adult social care for all Councils and SECAMB have been consulted and support the service change
What are the views of key stakeholders?		• There has been significant patient, public and carer engagement throughout the process. Feedback collected from over 500 people in the summer of 2015 found that people's top three priorities for when a stroke happens are a fast ambulance response time; quick diagnosis and treatment; and the quality of medical expertise. The vast majority of people said that they would be happy to travel further to get to a HASU but said their main concern about this would be the impact on relatives and carers. Feedback from patients since the temporary divert to PRH was introduced has been positive • There has also been a very small

		review of the experiences of patients affected by the PRH temporary divert shared with HASC in September 2016.
Do the Proposals meet the DH 4 key tests for service change?		• There has been support from all 3 CCG GP-led Clinical Executive Groups. • A group of more than 20 local clinicians - including hospital doctors, GPs, nurses, therapists, patient representatives and paramedics - has been involved in reviewing our current stroke services, feedback from patients and the latest evidence on best practice. • The expert independent clinical review group included 18 local and national specialists, including the national clinical director for stroke There is a compelling case for greater concentration of stroke services, outlined in the Sussex Stroke services Case for Change and evidence of improved outcomes for patients emerging from those services who have already reduced to location of services.

The Committee is asked:

- For confirmation that the committee is content with the evidence provided, detailing the benefits and risks of the Central Sussex Stroke Programme Board's recommendation to centralise Hyper Acute Stroke services and Acute Stroke services at the Royal Sussex County Hospital, Brighton
- To decide whether the change proposed (i.e. not re-commencing the stroke service at Princess Royal Hospital, Haywards Heath) is considered a 'substantial service change' requiring a formal public consultation

References

Youman P, Wilson K, Harraf F, Kalra L. The economic burden of stroke in the United Kingdom. Pharmacoeconomics 2003;21:43-50.

NHS England (2016) Stroke services: Configuration Decision support guide.

Version	Authors	Distribution	Amendments	Date
0.1	C.Huff	Terry Lynch, Peter Lane, Nicky Gainsborough, Mohit Sharma, Dan Wood		30/08/2016
0.2	C.Huff	File	Terry Lynch added. SECAMB travel added. Substantial change evidence completed.	12/09/2016
0.3	C.Huff	file	Dan Woods suggestions	13/09/2016
0.4	C.Huff	File and send to Helena Cox	Tracked changes and comments from Helena Cox	15/09/2016
0,5	H. Cox	C.Huff	Changes suggested to response required and	20/09/2016

			adding adult Social care. CH accepted tracks	
0.7	C. Huff	John Child, Gemma Dawson	Changes following the governing bodies, HASC/HOSC	30/09/2016

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 33 Brighton & Hove City Council

Subject:		**South East Coast Ambulance NHS Foundation Trust (SECAmb) Care Quality Commission (CQC) Inspection**
Date of Meeting:		**19 October 2016**
Report of:		**Executive Lead for Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-5514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The CQC is the statutory inspector of NHS-funded healthcare. The CQC has a rolling programme of inspection of NHS trusts.

1.2 SECAmb provides 999 and 111 ambulance services across Kent, Surrey and Sussex. The CQC undertook a full inspection of SECAMb services in May 2016. The findings of the CQC inspection were discussed with stakeholders at a Quality Summit on 28 September and the CQC's inspection report was published shortly after The summary report is included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That HOSC members note the contents of the CQC inspection report (see **Appendix 1**); and

2.2 that HOSC members agree that scrutiny of the implementation of SECAMb quality improvement measures in response to the CQC report findings be undertaken by an informal joint working group representing all the interested HOSCs in the SECAmb 'region'.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 SECAmb is an NHS foundation trust, providing emergency ambulance transport to residents of Kent, Surrey and Sussex. The trust was inspected by the CQC in May 2016, and the CQC inspection report was published in September 2016.

3.2 The CQC scores services at NHS trusts as: ***outstanding***, ***good***, ***requires improvement*** or ***inadequate***. Each service is judged against five performance domains: ***caring***, ***safe***, ***well-led***, ***responsive*** and ***effective***. As well as scoring each major trust service in each of these domains, the CQC produces an overall score for the trust against each domain, and an aggregated score for the trust as an organisation. If a trust is deemed overall to be ***inadequate***, or it has several

inadequate scores, then the CQC may advise NHS Improvement (NHSi), the NHS trust regulator, to place the trust in Special Measures. Trusts in Special Measures have access to additional improvement support.

3.3 The most recent CQC inspection report gives SECAmb an overall score of ***inadequate*** and the CQC has recommended that SECAmb be placed in special measures. Trusts are required to produce Quality Improvement Plans (QIP) setting out in detail their plans to improve services in response to CQC recommendations. The SECAmb QIP is still being developed and will be published shortly.

3.4 HOSCs have no prescribed role to play in CQC inspections, other than being asked for comment prior to an inspection. However, HOSCs generally seek to monitor the implementation of QIPs arising from CQC inspection reports, particularly where trust performance has been identified as poor.

3.5 Ambulance trusts typically operate over a large geographical area; for SECAmb this area encompanses Kent, Surrey and Sussex. This means that the trust is answerable to six HOSCs: Surrey County Council, Kent County Council, West Sussex County Council, East Sussex County Council, Brighton & Hove City Council, and Medway Council. In order to minimise duplication and ensure that scrutiny does not impose an undue burden on SECAmb, regional HOSC Chairs have proposed that monitoring the implementation of SECAmb's improvement actions be undertaken by a joint, informal meeting of all the interested HOSCs. As the Chairs of South East Coast HOSCs already meet regularly to network, the proposal is that this meeting should also be used to monitor SECAmb. This informal group would have no delegated powers, all of which would remain with the individual committees. Each HOSC Chair would report monitoring activities back to their HOSC and any further action would be determined by that HOSC.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The HOSC could choose not to further scrutinise this issue. However, HOSCs are expected to hold NHS providers to account for poor performance and it is clear that SECAmb is currently performing poorly.

4.2 The HOSC could decide to scrutinise this issue individually rather than via an informal joint meeting (although no formal delegation of powers is proposed). However, SECAmb is answerable to six HOSCs in total, and dealing with each individually would impose a significant burden on trust leaders as well as duplicating activities in terms of HOSC member time and in terms of support resources.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None undertaken in relation to this report.

6. CONCLUSION

6.1 This report presents the findings of the recent CQC inspection report for information as well as suggesting that ongoing scrutiny of this issue would best be managed via a joint, informal meeting of Chairs of the six interested HOSCs.

6.2 Any future substantive decision on this matter (e.g. to cease monitoring as significant improvements have been made; or to escalate concerns if no improvement occurs) would be the preserve of each individual HOSC, not of the informal joint working group.

7. FINANCIAL & OTHER IMPLICATIONS:

7.1 None for the council.

Legal Implications:

7.2 There are no legal implications arising from this report.

Lawyer Consulted: Elizabeth Culbert; Date: 26th September 2016

Equalities Implications:

7.3 None to this report, although such issues may form part of the scrutiny activity to be undertaken by the proposed informal working group.

Sustainability Implications:

7.4 None to this report, although such issues may form part of the scrutiny activity to be undertaken by the proposed informal working group.

Any Other Significant Implications:

7.5 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. SECAMb CQC inspection report summary

Documents in Members' Rooms

None

Background Documents

None

South East Coast Ambulance Service NHS Foundation Trust

Quality Report

The Horseshoe
Bolters Lane
Banstead
Surrey
SM7 2AS
Tel: 0300 1230999
Website: www.secamb.nhs.uk

Date of inspection visit: 03-06 May 2016
Date of publication: 29/09/2016

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is part of the National Health Service (NHS). The trust came into being on 1 July 2006, with the merger of the former Kent Ambulance Service, Surrey Ambulance Service and Sussex Ambulance Service. On 1 March 2011 SECAmb became a Foundation Trust. The trust employs over 3,660 staff working across 110 sites in Kent, Surrey and Sussex. This area covers 3,600 square miles which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country. It has a population of over 4.5 million people. There are 12 acute trusts within this area and 22 Care Commissioning Groups (CCGs).

The trust responds to 999 calls from the public and urgent calls from healthcare professional across Brighton and Hove, East Sussex, West Sussex, Kent and Medway, Surrey, and parts of North East Hampshire.It also provides NHS 111 services across the region and in Surrey provides non-emergency patient transport services (pre-booked patient journeys to and from healthcare facilities).

The emergency operations centre (EOC) receives and triages 999 calls from members of the public and other emergency services. It provides advice and dispatches ambulances as appropriate.The EOC also provides assessment and treatment advice to callers who do not need an ambulance response, a service known as “hear and treat”. Callers receive advice on how to care for themselves, or staff direct them to other services that could be of assistance.The EOC also manages requests from health care professionals to convey people either between hospitals or from community services into hospital.

The emergency operations centre received 929,822 emergency calls in 2014-15. The call volume had increased by 7.24% compared with the previous year.The trust had three emergency operations centres: Coxheath, Banstead and Lewes. The trust plans to move services from Banstead and Lewes EOCs to a new, purpose-built facility in Crawley in February 2017.

Patient Transport Services (PTS) for SECAmb provides a service for people who meet the eligibility criteria within Surrey and a small part of North East Hampshire. PTS headquarters is based in Dorking, Surrey and there are six bases across the area, located at or near the major hospitals. Figures provided show that PTS handles between 1800 and 1950 journeys per week and currently employs 126 staff.

We inspected this location as part of our planned comprehensive inspection programme. Our inspection took place on 3 to 6 May 2016. We looked at three core services: emergency operations centres, patient transport services and emergency and urgent care, including resilience and the hazardous area response team. The 111 service provided by the trust was inspected separately. During the inspection, we visited both ambulance premises and hospital locations in order to speak to patients and staff about the ambulance service.

Overall, we rated this service as inadequate. We rated emergency and urgent care as inadequate and the emergency operations centre and patient transport services as requires improvement.

Overall we rated the service as good for caring, requiresimprovement for effective and responsiveand inadequate for safe and well led.

Our key findings were as follows:

Are services safe?

- The incident reporting culture, the processes for reporting and investigating incidents and the lack of learning from incidents did not support the safe provision of service.
- Safeguarding arrangements within the trust were exceptionally weak. A lack of accountability, understanding and appropriate investigation was prevalent throughout the trust.
- There was low attendance at infection control training leading to inconsistent hand hygiene practices.
- The trust CAD system had not been appropriately updated.
- The trust medicines management process had allowed staff to develop practice outside national guidance and best practice.

Summary of findings

- Low staffing levels were having an impact on both performance and fatigue of staff. The trust did not have access to information to review the mix of staff or safe staffing levels.

Are services effective?

- The trust was not meeting national performance targets for response times.
- The trust was benchmarked as the worst performing trust nationally for answering 999 calls within 5 seconds. Trust performance was as low as 95% within 80 seconds during March 2016.
- Policies and procedures had not been updated in a timely manner or in line with national guidelines.
- There was no tracking system for appraisals leading to inconsistencies in approach.
- There was no competency framework in place against which to assess staff.
- There was a lack of Mental Capacity Act training leading to a variable understanding within the trust.
- There were protocols and guidance for pain relief and patients reported that pain relief had been offered and managed effectively.
- The trust had well developed links with the police, fire brigade and GPs.

Are services caring?

- Our observation of staff interacting with patients demonstrated patient empathy and focus.
- We saw kindness and understanding from staff even when faced by volatile patients and members of the public.
- We saw examples of staff providing patients, relatives and colleagues emotional support.
- Call handlers in the 111 service communicated with callers in a non-judgemental way and treated patients as individuals.
- Ambulance crews largely provided clear explanations to patients adopting a sensitive tone and posture during discussions.
- PTS staff sensitively supported patients to find alternative modes of transport when they did not meet the criteria for accessing PTS.
- There were processes to ensure that staff could access support following traumatic or difficult calls or attendances. Staff were observed providing immediate support to colleagues.

Are services responsive?

- The processes for complaint response failed to meet expected targets. Complaints did not fully acknowledge organisational responsibility and there was little evidence of learning from complaints across the whole trust.
- Organisational planning had not facilitated equal distribution of resources across the geographical area served.
- A 'tethering' system resulted in some patients waiting longer than necessary for emergency attendances.
- Handover delays at emergency departments often significantly exceeded the 15 minutes target and led to a major loss of productive ambulance capacity.
- The trust was working closely with commissioners to plan services against the background of significant increases in demand.
- The trust worked with strategic clinical networks, operational delivery networks and the trauma network to plan for complex care.

Are services well-led?

- Roles and accountability within the executive team lacked clarity.
- There was a lack of clarity regarding the respective roles of the three clinical directors within the executive team.
- The board had numerous interim post holders and we saw evidence of inter-executive grievance.
- Although there was a comprehensive clinical strategy, there was no form of measurement to monitor the attainment of the strategy pledges by the board.
- Risk management was not structured in a way that allowed active identification and escalation to the board. Risks managed at board level did not have robust and monitored action plans.
- Staff reported a culture of bullying and harassment.
- The trust had actively sought to engage with the public, notably with the development of community first responders.
- The trust was utilising social media in an attempt to inform and influence the use of trust services.
- The trust had a positive culture of encouraging innovation, notably in the development of the paramedic workforce and the introduction of critical care and advanced paramedics.

We saw several areas of outstanding practice including:

Summary of findings

- The trust encouraged staff to take on additional roles and responsibilities and provided training and support to enhance the paramedic roles. The specialist paramedics' roles such as the critical care paramedic had expanded and developed.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- take action to ensure all staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns receive an appropriate level of safeguarding training.
- take action to ensure all Emergency Operations Centre premises containing confidential data and critical equipment are secure.
- take action to ensure the CAD system is properly maintained.
- take action to provide every operational Hazardous Area Response Team (HART) operative with no less than 37.5 hours protected training time every seven weeks.
- formulate a contingency plan to mitigate the loss of the Patient Transport Services control room in Dorking that will allow the service to continue.
- take action to ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services.
- take action to improve the reporting of low harm and near miss incidents.
- take action to ensure that national performance targets are met.
- take action to improve outcomes for patients who receive care and treatment.
- take action to adequately manage the risk of infection prevention and control. This includes ensuring consistent standards of cleanliness in the ambulance stations, vehicles and staff hand hygiene practices.
- take action to ensure there are always sufficient numbers of staff and managers to meet patient safety and operational standards requirements. This should include ensuring there are adequate resources for staff to usually take their meal breaks, finish on time, undertake administrative and training.
- take action to recruit to the required level of HART paramedics in order to meet its requirements under the National Ambulance Resilience (NARU) specification.
- ensure that ambulance crews qualifications, experience and capabilities are taken into account when allocating crews to ensure that patients are not put at risk from inexperienced and unqualified crews working together.
- take action to protect patients from the risks associated with the unsafe use and management of medicines. This should include: appropriate use of patient group directives; the security and safe storage of both medicines and controlled drugs; the management of medical gas cylinders.
- take action to ensure that patient records are completed appropriately, kept confidential and stored securely.

In addition the trust should:

- take action to review all out-of-date policies and standard operating procedures.
- develop procedures to ensure HART rapid response vehicles (RRVs) are relieved to attend HART incidents within the timescales set out in standards 08-11 of appendix three of the NHS service specification 2015-16: Hazardous area response teams.
- take action to audit 999 calls at a frequency that meets evidence-based guidelines.
- take action to put in place an effective and consistent process for feedback to be given to those who report incidents and develop a robust system for sharing lessons learned from incidents.
- take action to ensure all staff receive an annual appraisal in a timely fashion in order that they can be supported with training, professional development and supervision.
- take action to address discrepancies in the number of funded ambulance hours with activity across the trust.
- ensure all first aid bags have a consistent list of contents, stored securely within the bags.
- devise a system that will accurately track the whereabouts of the PTS defibrillators.

Summary of findings

- include a question regarding the patient's DNACPR status at the point of each transport booking.
- provide Mental Capacity Act and Deprivation of Liberty Safeguards training to all operational staff.
- take action to engage staff in the organisations strategy, vision and core values.This includes increasing the visibility and day to day involvement of the trust executive team and board across all departments.
- develop a detailed and sustained action plan to address the findings of the staff survey including addressing the perceived culture of bullying and harassment.
- continue to take action to address the handover delays at the acute hospitals.
- ensure there are adequate resources available to undertake regular audits and robust monitoring of the services it provided.
- ensure that there is adequate access to computers at ambulance stations to facilitate e-learning, incident reporting and learning from incidents.
- ensure there is a robust system in place to manage, investigate and respond and learn from complaints.This includes ensuring that all staff understand the Duty of Candour and their responsibilities under it.
- ensure that there is appropriate trust wide guidance and training provided regarding attending patients with mental health problems. This should include reviewing the current arrangements for assessing capacity and consent.
- ensure that there are structured plans in place for all frequent callers as per national guidance. The information regarding this should be collected and monitored as per national guidelines.
- ensure that there are systems and resources available to monitor and assess the competency of staff. This includes ensuring they always involve patients in the care and treatment and treat them with dignity and respect.
- ensure there are robust systems in place to ensure all medical equipment is adequately serviced and maintained.
- ensure that vehicles and ambulance stations are kept secure.
- ensure that there is sufficient time for vehicle crews to undertake their daily vehicle checks within their allocated shift pattern.

Professor Sir Mike Richards

Summary of findings

Chief Inspector of Hospitals

Summary of findings

Background to South East Coast Ambulance Service NHS Foundation Trust

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is part of the National Health Service (NHS). The trust came into being on 1 July 2006, with the merger of the former Kent Ambulance Service, Surrey Ambulance Service and Sussex Ambulance Service. On 1 March 2011 SECAmb became a Foundation Trust. The trust employs over 3,660 staff working across 110 sites in Kent, Surrey and Sussex. This area covers 3,600 square miles which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country. It has a population of over 4.5 million people. There are 12 acute trusts within this area and 22 Care Commissioning Groups (CCGs).

The trust responds to 999 calls from the public and urgent calls from healthcare professional across Brighton and Hove, East Sussex, West Sussex, Kent and Medway, Surrey, and parts of North East Hampshire. It also provides NHS 111 services across the region and in Surrey provides non-emergency patient transport services (pre-booked patient journeys to and from healthcare facilities).

The emergency operations centre (EOC) receives and triages 999 calls from members of the public and other emergency services. It provides advice and dispatches ambulances as appropriate. The EOC also provides assessment and treatment advice to callers who do not need an ambulance response, a service known as “hear and treat”. Callers receive advice on how to care for themselves, or staff direct them to other services that could be of assistance. The EOC also manages requests from health care professionals to convey people either between hospitals or from community services into hospital.

The emergency operations centre received 929,822 emergency calls in 2014-15. The call volume had increased by 7.24% compared with the previous year. The trust had three emergency operations centres: Coxheath, Banstead and Lewes. The trust plans to move services from Banstead and Lewes EOCs to a new, purpose-built facility in Crawley in February 2017.

Patient Transport Services (PTS) for SECAmb provides a service for people who meet the eligibility criteria within Surrey and a small part of North East Hampshire. PTS headquarters is based in Dorking, Surrey and there are six bases across the area, located at or near the major hospitals. Figures provided show that PTS handles between 1800 and 1950 journeys per week and currently employs 126 staff.

We inspected this location as part of our planned comprehensive inspection programme. Our inspection took place on 3 to 6 May 2016. We looked at three core services: emergency operations centres, patient transport services and emergency and urgent care, including resilience and the hazardous area response team. The 111 service provided by the trust was inspected separately. During the inspection, we visited both ambulance premises and hospital locations in order to speak to patients and staff about the ambulance service.

Our inspection team

Our inspection team was led by:

Chair: Sarah Faulkner, Director of Quality/Executive Nurse, The North West Ambulance Service NHS Trust

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

The team of 40 included CQC inspectors and inspection managers, a pharmacy inspector, an analyst and an inspection planner and a variety of specialists. The team of specialists included a nurse consultant and staff nurse working in

emergency departments, a medical director, ambulance operations managers, paramedic staff including a critical care paramedic and a clinical team leader, an emergency care technician and a senior emergency care practitioner, a safeguarding lead, a head of governance, staff from patient transport services, a HART manager, a call centre manager, an emergency operations centre dispatcher and a community first responder.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The inspection took place from 3-6 May 2016.

The inspection team inspected the following:

• Emergency Operations Centres

• Emergency and Urgent Care including the Hazardous Area Response Team (HART).

• Patient Transport Services

The 111 service was inspected separately.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the South East Coast Ambulance Service. These included local clinical commissioning groups (CCGs); local quality surveillance groups; the health regulator, Monitor; NHS England; Health Education England (HEE); College of Emergency Medicine; General Dental Council; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; National Peer Review Programme; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Public Health England; the medical royal colleges; local authorities, local NHS Complaints Advocacy Service; local Healthwatch groups; and local health overview and scrutiny committees. The inspection team also spoke to 105 staff trust-wide at focus groups the week before the inspection.

We visited all three EOC sites. We spoke to 39 staff during our visits. We spoke to staff from the following staff groups: call handlers, dispatchers, clinicians, managers, paramedics, development coaches, infection prevention and control, and safeguarding. We spoke with the relatives and carers of two patients. We also reviewed patient feedback from the compliments boards at Coxheath and Lewes EOCs, four patient complaints and the 2014 national ""hear and treat "survey. The hear and treat survey measured the experiences of patients who received medical advice over the telephone to manage their conditions. We also examined information sent to us by the public and other stakeholders such as Healthwatch.

During the inspection, we visited 23 ambulance stations, two hazardous area response teams (HART) and four community first responder posts across Kent, Surrey and Sussex. We also inspected the emergency and urgent care support services such as the make ready centres, fleet management and maintenance centres as well as the commissioning and decommissioning centre. We inspected ambulances and reviewed patient records. We also attended 17 hospitals, where we observed the interaction between ambulance crews and hospital staff. We spoke with over 30 emergency department staff to get feedback on the service provided by the ambulance trust.

Summary of findings

We spoke with over 150 emergency and urgent care staff in various roles including paramedics, emergency medical technicians, paramedic students, team leaders, duty station officers, senior managers and community first responders. We reviewed 25 sets of patient care records. We spoke with 31 emergency department patients and their relatives who had used the service. We also observed over 30 patient handovers at emergency departments. We rode, and observed staff-patient interactions and care, on emergency ambulances.

During our inspection we spoke with PTS staff including the PTS co-ordinators, booking staff and senior managers. We observed the work of staff at all the major hospitals. We looked at vehicle maintenance, cleanliness, the planning of vehicle servicing and MOT testing. We also spoke with patients who used the service as well as assessing outcomes from patient satisfaction surveys.

We would like to thank all staff, patients and other stakeholders for sharing their balanced views and experiences of the quality of care provided by the South East Coast Ambulance Service NHS Foundation Trust.

Facts and data about this trust

1. Context

- The emergency and urgent care service and the NHS111 service cover Kent, Surrey and Sussex.
- Patient Transport Services operate in Surrey.
- The area covers 3,600 square miles with a population of more than 4.5 million.
- There are 12 acute trusts and 22 Clinical Commissioning Groups.
- The service has over 110 sites. These include 45 Ambulance Stations, six Make Ready Centres, 59 Ambulance Community Response Posts, two Hazardous Area Response (HART) Centres and two stand-alone Vehicle Maintenance Centres.
- There are two regional offices at Lewes and Coxheath and the Trust HQ at Banstead. Each of these sites also houses an Emergency Operations Centre (EOC) where 999 calls are received, clinical advice provided and emergency vehicles dispatched if needed.
- There are two Contact Centres at Dorking and Ashford where 111 calls are received and responded to.
- Staff: Over 3,600 staff across Kent, Surrey and Sussex, including over one thousand registered clinical staff and over 900 clinical support staff.
- Trust revenue for April 2015 – March 2016 was £249 million with a surplus of £2.2 million.

2. Activity in 2014/15

- 929,822 emergency calls.
- 380,799 non-emergency patient journeys.

3. Safe

- National Reporting and Learning System (NRLS reporting): between February 2015 and March 2016 the trust reported 505 incidents. The majority of these (62%) were classed as no harm. Twenty one incidents were classed as 'severe' and 17 of these were grouped under 'treatment/procedure'. There were no never events.
- Staff survey: the trust scored worse than the national average on questions relating to the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month , the fairness and effectiveness of procedures for reporting errors, near misses and incidents , and on staff confidence and security in reporting unsafe clinical practice . They scored the same as the national average on the percentage of staff reporting errors, near misses or incidents witnessed in the last month.

4. Effective

Emergency response times

- Between April 2015 and March 2016, 71.6% of 999 Red 1 calls received an emergency response within eight minutes after the EOC received the call. This was worse than the national target of 75%.
- Between April 2015 and March 2016, 67.3% of 999 Red 2 calls received an emergency response within eight

minutes. This was worse than the 75% national target. SECAmb was the fifth worst performing out of 11 ambulance trusts in England for Red 2 response times during this period.

- The trust did not meet the AQI A19 target for Red 1 and Red 2 (combined) in 2015-16. This standard required that a vehicle able to transport a patient to hospital following a Red 1 or Red 2 response arrived within 19 minutes. Between April 2015 and March 2016, the trust met this standard for 93.8% of these calls. This was worse than the national target of 95%.

Ambulance clinical performance indicators (comparison between trusts) (January 2016 data)

- The data indicated that the outcomes for SECAmb patients who had a cardiac arrest was worse than the national average. There was deterioration in the statistics since last year. However, stroke patients were more likely to arrive at a specialist stroke unit quicker than the national average.
- The percentage of patients (66.7%) who received the appropriate care bundle for STEMI was worse than the England average of 80%.
- The percentage of of patients (87.6%) who received primary angioplasty within 150 minutes was the same as the England average.
- The percentage of patients (23%) who had return of spontaneous circulation on arrival at hospital was worse than the England average of 26%.
- The percentage of patients (3%) who were discharged from hospital alive having had resuscitation commenced or continued by ambulance crew following a cardiac arrest was worse that the England average of 6%. This was the smallest proportion across all the ambulance trusts and was significantly worse than the data for the previous year and below the average for 2014-15 of 8.5%.
- In the Utstein comparator group, 20% of patients were discharged from hospital alive which was the same as the England average in January 2016.
- The percentage of Face Arm Speech Test positive patients (61%) who arrived at a hyper-acute stroke unit within 60 minutes was better than the England average of 52%.

Treatment

- Between April 2015 and March 2016, the trust reported a “hear and treat” rate (emergency calls resolved by telephone advice) of 10.2%.This was the same as the England average for the same period. However, for the last three months of this period, the trust’s hear and treat rates were consistently worse than the England averages.
- The proportion of patients who re-contacted following treatment and discharge at the scene, within 24 hours is worse than the England average.
- The percentage of patients discharged, after treatment at the scene or onward referral to an alternative care pathway, and those with a patient journey to a destination other than type one or two A&E (‘see and treat’) is higher than the England average.

5. Caring

- The trust scored similar to other trusts for most questions on call handling, clinical advice and outcome, but worse than the national average on ‘did they listen to what you had to say’.

6. Responsive

Call answering

- The average time to answer a 999 call was consistently in line with the maximum of all trusts (3 seconds) , and in August 2015 some calls were taking as long as 140 seconds to be answered.
- The proportion of calls abandoned before being answered is lower than the England average for 12 out of 18 months (July 2014 – December 2015).
- The proportion of patients who re-contacted the service following discharge of care, by telephone within 24 hours is higher than the England average by an average of 1% per month.

Summary of findings

Patient Transport Services

- Patient transport contract key performance indicator times were not met overall.

7. Well Led

- NHS staff survey 2015: overall the trust scored worse than average for 16 questions, including the percentage of staff experiencing discrimination at work in last 12 months , the percentage of staff working extra hours , the quality of non-mandatory training, learning or development and the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months .

8. CQC inspection history

- 4 inspections since 2010.
- Compliant at last inspection December 2013.

Summary of findings

Our judgements about each of our five key questions

Rating

Are services at this trust safe?

Inadequate

We rated the trust as inadequate for safety. This was because:-

- Emergency and Urgent Care and 111 services were both rated as inadequate. Emergency Operations Centre and Patient Transport Services were both rated as requires improvement.
- The incident reporting culture, processes for reporting and investigating incidents and lack of learning from incidents did not support the safe provision of service.
- Safeguarding arrangements within the trust were exceptionally weak. A lack of accountability, understanding and appropriate investigation was prevalent throughout the trust.
- The trust had low attendance at infection control training leading to inconsistent hand hygiene practice.
- The trust CAD system had not been appropriately updated.
- Low staffing levels were having an impact on both performance and fatigue of staff. The trust did not have access to information to review the mix of staff or safe staffing levels.

Incidents

- The trust operated an incident reporting process that was supported by an Incident Reporting and Investigation Manual. At the time of inspection this manual was beyond its scheduled review date.
- During the time period May 2015 to April 2016 the trust reported 57 serious incidents. 42% of these were reported as causing delay to treatment.
- During the inspection staff interviewed indicated that they were aware of the incident reporting process. However, a culture of under reporting incidents existed within the trust driven by work pressure constraints. Low risk or near miss incidents appeared unlikely to be reported.
- It is likely that the low reporting culture is further exacerbated by the lack of feedback mechanisms to staff following the reporting of an incident. A number of staff indicated a view that nothing changes as a result of incident reporting.

Summary of findings

- Staff bulletins included, on some occasions, examples of learning from incidents. However, we did not see strong evidence of either thematic review or cross organisational learning from incidents. Serious incidents within the 111 service were not shared across the trust.
- The trust lacks a systematic approach to the management of incidents. As a result both patient transport services and the emergency operations centre had developed significant backlogs. Staff informed us that the trust had 3,300 open incidents awaiting investigation and were unable to advise the inspection team as to whether these incidents had been closed.
- The trust acknowledges the impact of workload pressures on staff on the reporting of incidents and are seeking to introduce tablet based systems to allow more rapid access for staff to incident reporting.
- Duty of candour was not well understood within the trust. This extended to senior staff holding prominent positions in operational, risk and safeguarding management who were unable to articulate the principles of duty of candour.

Mandatory Training

- The trust basic mandatory training portfolio was of appropriate content and access was largely on line training with some face to face. However, we have noted in our report the lack of access to mental health and dementia awareness training.
- Staff attendance rates for mandatory training were largely good with most exceeding the trust target of 95%.
- However we have indicated in our report that an area of concern is the lack of protected training time provided for the Hazardous Area Response Team (HART).
- Staff were provided protected time to complete mandatory training requirements.
- Driver training was managed in accordance with regulations and staff received, where appropriate, emergency response driving training. The trust has a robust plan to meet the five year reassessment of drivers.

Safeguarding and complaints

- The trust has a comprehensive safeguarding policy that is supported by safeguarding referrals guidance.
- The trust has a dedicated safeguarding team which reports into the trust clinical governance system. This included a designated non-executive director.

Summary of findings

- However, evidence provided by the trust did not include an annual safeguarding report to the board. Review of board agendas from May 2015 to the date of inspection supported the view that no report had been received at trust board.
- Formalised links with county safeguarding boards had not been used to maximum effect and there was no evidence of learning from serious case reviews.
- The board had identified the risk of not sharing information with local authorities in March 2014 but this risk remained, largely unmitigated, on the register in March 2016.
- Senior and middle managers, when interviewed, were unclear about their role in safeguarding. This included when allegations were made against staff.
- The trust policy for managing abuse allegations was dated June 2015 and provided no indication of board approval.
- During the inspection we reviewed two complaints where allegations of abusive behaviour by staff had been made. No subsequent safeguarding investigation had been made and the overall investigation lacked formality and purpose with a lack of external evidence sought.
- The trust did not have a system for robustly tracking safeguarding referrals and operational staff received no feedback following referral.
- Safeguarding training was provided to trust staff and we saw evidence of content of safeguarding training updates. However, the training provided to clinical staff (including paramedics)was at level 2 rather than the required level 3. An exception to this was the 111 service where clinical staff were all trained to level 3.
- Further to the level of training received only 70% of staff had attended level 2 training. There was a lack of clarity regarding accountability for training levels within the trust.
- Ambulance crews when interviewed failed to recognise the vulnerabilities of looked after children. In addition operational staff were not clear on the process for contacting the safeguarding lead.
- When reviewing incident records we identified an incident in which a vulnerable patient was left unattended for a considerable period of time. The crew attending did not consider this a safeguarding issue and no further referral was made.
- PREVENT (anti-radicalisation training) had been initiated. Safeguarding workbooks were available to staff.

Summary of findings

Cleanliness, infection control and hygiene

- The trust had an Infection Prevention and Control manual and had a dedicated infection control team.
- It was unclear from our interviews with managers and staff who was accountable for monitoring and maintaining infection control standards.
- In ambulance stations in particular there was a lack of frequency and completion of audits. As a result we saw examples of poor waste management processes.
- 74% of staff had attended infection prevention and control training in the year prior to inspection, which was below the trust standard of 95%.
- The trust was progressing a strategy of 'make ready centres'. Our observations during the inspection and feedback from staff indicated that this was proving successful in maintaining cleanliness and hygiene standards.
- However we observed poor standards from non make ready prepared vehicles including a lack of hand hygiene gel dispensers.
- Although hand gel dispensers were largely available our observations indicated that staff frequently failed to carry personal dispensers and observe hand hygiene best practice. Some staff had adopted the use of detergent wipes rather than recognised hand cleansing.

Environment and equipment

- Vehicles were serviced in accordance with Ministry of Transport requirement and a servicing recall system was in place. Staff reported that repairs services operated well.
- Staff largely had access to required equipment to deliver service. However, on PTS vehicles there was not always access to defibrillators and comprehensive first aid kits.
- On emergency vehicles there were processes to check kit inventory, however staff reported a lack of pressure cuffs .
- Processes for the general management of equipment were however weak with the trust not operating a central asset register and equipment not identified by an asset label.
- The standard of buildings used across the trust was variable. Whilst some constituted modern accommodation some ambulance stations were in poor repair.

Summary of findings

- EOC accommodation did not provide access for disabled staff and in one EOC we identified an electrical fire hazard. PTS office accommodation was not optimal both inhibiting communication by mobile telephone and providing cramped and unsuitable conditions of work.
- During the inspection we identified a major security breach at an ambulance station. We found the station unlocked and unattended with potential access to vehicles, uniforms, medicines and records.
- One of the EOC was also identified as a security risk due to uncontrolled access following poor maintenance.
- The storage of medical gases on a number of locations did not meet safety standards.

Medicines

- The trust has a Drugs and Therapeutics Committee which reports to the Risk Management and Clinical Governance Committee.
- Policies, procedures and guidelines are in place to ensure the safe and effective use of medicines. However, poor distribution and replacement processes resulted in old policies being in use.
- The trust uses patient group directions (PGD) to allow the supply and administration of urgent medicines by paramedic and nurses. Whilst having appropriate authorisation, PGDs, with the exception of one ambulance station, were out of date.
- Non registered staff (community first responders, associate practitioners and ambulance technicians) were authorised to administer prescription only medicines and registered staff (paramedics and nurses) authorised to administer an off license medicine. Whilst this practice is consistent with some other ambulance trusts it is different to practice in acute hospitals and we are currently seeking clarification of compliance with medicines legislation.
- The use of a biometric medicines storage cabinet to hold medicines has been introduced and proved successful in enhancing monitoring, security and stock control.
- However, where this was not implemented we observed examples where medicines, including controlled drugs, were not stored securely and monitored appropriately. We also saw examples of the inappropriate disposal of part used controlled drugs.

Summary of findings

Records and IT systems

- In the emergency care environment the trust had a paper based system using patient record forms. This system allowed electronic scanning when records were returned to the central records store.
- The trust audited the quality of records held, however these results were not shared with managers and subsequently staff for performance improvement purposes.
- Our audit of patient records during inspection indicated that patient assessments were often incomplete including low frequency of observations.
- The trust also used an intelligence based information system IBIS. This allowed for the holding of additional information including care pathways and DNA CPR on patients identified as complex and high risk by community health services. Staff had confidence in this system.
- The trust considered the instability of the CAD (Computer Assisted Dispatch) to be a significant risk and had as such placed it on the risk register. Staff described a recent upgrade as detrimental to functionality and performance.
- The CAD Gazeteer had not been updated for eighteen months. NHS England currently recommend six weekly updates. The trust was not appreciative of this risk, having not addressed and responded to a safety alert, and its potential impact upon reaching patients in a timely manner.

Assessing and responding to patient risk

- In the emergency care setting patient risk assessment was appropriately undertaken using early warning scores and clinical pathways.
- Processes for the recognition and management of deteriorating patients were in place.
- Staff from emergency departments at acute hospitals advised us that handover was comprehensive. However, our observations during inspection identified both gaps in handover detail and on one occasion inappropriate handover by a support worker.
- EOC services used recognised triage and prioritisation pathways.
- Clinical support to waiting patients was provided via telephone welfare checks. We saw evidence of triage upgrade following welfare calls.

- PTS staff were aware of action required in the event of a patient deteriorating.

Staffing and capacity risk

- Maintaining safe staffing levels was problematic for all operational areas of the trust. The trust had a 44% staff turnover rate. The sickness rate was 3% and agency usage was low.
- Staff were rostered using an electronic system. Staff expressed dissatisfaction with the system citing inconsiderate gaps between shifts.
- The roster system did not afford management the information to assess safe staffing and skill mix.
- We observed and heard from staff that crews with an inappropriate skill mix were despatched to emergencies. The trust had no means of assessing the frequency of such events and few were reported as incidents.
- Staff reported intense fatigue with shifts extending beyond scheduled hours and meal breaks often interrupted. In addition, staff shortages were largely covered by overtime.
- The trust employed a REAP (Resource Escalatory Action Plan), however the trust had been operating at a high REAP level for a sustained period.
- The impact of this was to impede managerial function as resource was diverted to operational activity. A further consequence was an acceptance of this level as the norm and a lack of urgency in escalation.
- The HART was below full establishment resulting in an operational service for only 70% of the required time.
- In the EOC there was a shortfall of over 18 whole time equivalent paramedics from an establishment of 27. Continued clinical support was provided by telephone cross cover from other EOC's but placed intense pressure on staff.
- The established call handler workforce was 171 wte. At the time of inspection there was only 133 in post. This had a subsequent impact on the services ability to promptly answer 999 calls.
- At times of high activity the EOC had planned overspill areas to extend capacity.
- Vacancies also occurred within PTS, however the operational impact was less severe.
- 111 services also experienced significant shortfalls in staffing leading to performance issues. This regularly occurred in early morning, evening and weekend shifts.

Summary of findings

Major incident awareness

- The trust had a documented major incident policy and engaged in EMERGO training exercises.
- The service was widely commended by the public and other services for its response to the Shoreham air disaster.

Are services at this trust effective?

Requires improvement

We have rated the trust as requires improvement for effectiveness. This is because:-

- The emergency and urgent care service, the 111 service and EOC were all rated as requires improvement and PTS services were rated as good.
- The trust was not meeting performance targets for response times.
- Policies and procedures had not been updated in a timely manner or in line with national guidance.
- There was no tracking system for appraisals leading to inconsistency in approach.
- There was not a competency framework in place against which to assess staff.
- There was a lack of MCA training provided to staff leading to a variable level of understanding within the trust.

Evidence-based care and treatment

- The trust had developed care pathway, policies and protocols in line with NICE (National Institute of Health and Care Excellence) guidelines. Staff largely found these accessible and demonstrated an awareness of them.
- However, we found a number of policies in both the emergency and urgent care and the EOC that were beyond review date. In the EOC 50% of policies had not been reviewed since 2012 despite two Joint Royal Colleges Ambulance Liaison Committee (JRCALC) updates during that time period.
- There was little evidence of a programme of continuous clinical audit. Concern had been expressed by commissioners regarding the standard and frequency of audit. The clinical audit team lacked senior clinical oversight.
- The trust was not auditing call handler responses in line with their NHS Pathways licence. Of the required three audits per month 28% of staff had only received one audit.

Summary of findings

Assessment and planning of care

- Triage arrangements for calls received by the EOC were categorised in line with national guidance. This included a body map screen to enhance clinical assessment.
- An appropriate up to date multi-agency policy was in place for conveyance of patients under the Mental Health Act.
- The trust had a register of community first responders (CFR). However, issues relating to the CAD contributed to CFR impact not being maximised. The board recognised the need to enhance the impact of CFR but had not planned an improved form of delivery.
- Processes to ensure that PTS were advised of any special requirements for patients being discharged from hospital were in place.
- There were protocols and guidance for pain relief available to staff and patients reported that pain relief had been offered and managed effectively.The trust did not audit patient satisfaction of pain relief.

Response times

- The trust was not meeting national performance targets for response times.
- RED1 calls (those of life threatening nature) were not always attended to within the eight minute target. Between April 2015 and March 2016 only 71% met the target against the expected performance level of 75%.
- RED2 calls (less urgent but including stroke and fits) were not always attended to within the eight minutes plus I minute additional telephone time target. Between April 2015 and March 2016 only 67.3% met the target against the expected performance level of 75%.
- The trust was just below (93.8%) the 95% target for combined RED1 and RED2 response for 19 minute transfer to hospital.
- Performance was significantly varied between ambulances despatched by different EOC's. For one EOC daily performance was as low as 33.3% (RED1) and 55.8% (RED2).
- The trust was benchmarked as the worst performing trust nationally for answering 999 calls within five seconds. Trust performance was as low as 95% within 80 seconds during March 2016.

Summary of findings

- This delay may be exacerbated by the practice of a two minute wrap up time between calls, which was considered by the inspection team as excessive.
- Call abandonment rates for EOC were better than the national average, however for the 111 service abandonment levels were high and in excess of 17% for March 2016.
- Daily 111 service performance for answering calls within 60 seconds was highly variable ranging from 20.4% to 98.5% during April 2016.

Patient outcomes

- Year to date data reported in January 2016 indicated that the trust was performing worse (66.7%) against the national average (80%) for patients receiving the full care bundle for STEMI (Heart attack). However, the percentage of patients receiving primary angioplasty within 150 minutes (87.6%) was the same as the national average.
- 23% of patients had attained return of spontaneous circulation (ROSC) on arrival at hospital which was below the national average (26%). Using the Utstein comparator group data to measure the management of cardiac arrest the trust attained 31.3% ROSC which was worse than the England average of 44.3%.
- The proportion of patients discharged alive following cardiac arrest was 3%, worse than the England average and a deterioration from the 2014-15 position. The proportion of patients discharged alive using the Utstein comparator group was 20% which was the same as the England average.
- 61% of stroke patients arrived at a hospital within 60 minutes which was better than the national average(52%).
- However, 96.4% of suspected stroke patients received the appropriate care bundle, which was worse than the England average 97.8%.
- The 'hear and treat' rates for the trust had deteriorated to below the national average between January and March 2016.

Competent staff

- There were comprehensive induction programmes for call handlers and PTS staff. Feedback from emergency and urgent care staff suggested that their induction programme did not fully prepare them for the role.

Summary of findings

- In addition, we heard from a new member of staff being placed with relatively inexperienced colleagues.
- All paramedics were registered with the Health and Care Professions Council (HCPC) and process of revalidation was in place.
- The trust did not have a controlled process for tracking appraisals. This led to an inconsistent approach to re-appraisal with some staff having multiple appraisals during a time periods whilst others received none.
- Appraisal rates were good across a number of ambulance stations, however some performed less well bringing the trust wide average down to 72%, below the trust target of 100%.
- Appraisal rates in EOC's were lower at 60% and PTS staff reported high compliance with appraisals.
- The trust had built excellent links with universities to develop paramedic education both generally and as specialist critical care and advanced paramedics.
- Paramedics received clinical supervision on a regular basis.
- However, there was no recognised competency framework in use for assessing staff within the emergency and urgent care service.
- The trust had introduced performance coaches into the EOC to support staff development. Coaches were particularly directed towards supporting staff following call audit.
- CRF volunteers received key skills training from the trust.

Coordination with other providers

- The trust had well developed links with the police, fire brigade and GP's and the efficiency of these links daily.
- Over 18% of calls to 999 were referred from NHS111 services and a number of which had no apparent basis for referral. We were provided no evidence from the trust that this was subject to audit.
- PTS services maintained good relationships with acute hospitals and other service users. The introduction of PTS co-ordinators on trust sites had improved processes for patient discharge to home.

Summary of findings

Multidisciplinary working

- We observed call handlers being provided excellent support from clinicians within EOC. However, the pressurised performance environment led to some strains between emergency crews and the EOC.
- The trust had planned multidisciplinary away days to enhance joint working and communication.
- The trust provided HALO (hospital ambulance liaison officers) to acute trust emergency departments during periods of escalation. The acute trusts were largely complimentary of their ability to working alongside their staff.

Access to information

- Mobile ambulance staff found accessing information difficult and some described a lack of computer terminals at ambulance stations. The trust was in the process of implementing mobile tablets and were experiencing some initial connectivity problems.
- EOC staff had access to community health directories of service in order to signpost appropriate services.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Staff across the trust reported to us during the inspection that there was an absence of training relating to mental capacity.
- Our observations of ambulance crews demonstrated the appropriate use of consent.
- However, non-conveyance patients were not always provided with a full explanation of the reasons for documentation.

Are services at this trust caring?

Good

We rated the trust as good for caring. This was because:-

- All services inspected received the rating of good.
- Our observations of staff demonstrated patient empathy and focus.
- We saw kindness and understanding from staff even when faced by volatile patients and public.
- We saw during the inspection examples of staff providing patients, relatives and colleagues emotional support.

Summary of findings

Compassionate care

- During our inspection we heard numerous examples of compassionate care displayed by ambulance staff. This was supported by our observations of staff in their interaction with patients and carers.
- Ambulance staff were aware and sensitive to the dignity and respect of patients ensuring that they were transported with appropriate blanket coverage.
- EOC staff remained calm and patient focused when receiving calls. Carers, when interviewed, endorsed our observed findings.
- Staff across all services introduced themselves when interacting with patients. The PTS survey endorsed this with over 98% of patients responding that they had been treated with dignity.
- Call handlers in the 111 service communicated with callers in a non-judgemental way and treated patients as individuals.

Understanding and involvement of patients and those close to them

- Ambulance crews largely provided clear explanations to patients adopting a sensitive tone and posture during discussions. Patient feedback supported our observations.
- We were provided with a number of examples where EOC call handlers had supported childbirth and significant acute illness. Staff listened to callers and provided clear instructions. Although our observations supported these examples, the national hear and treat survey scored lower than the national average for feeling that the caller was listening to.
- PTS staff sensitively supported patients to find alternative modes of transport when they did not meet the criteria for accessing PTS.
- 111 call handlers regularly checked understanding with callers. Staff closed the call by clearing restating what was being asked of the caller.

Emotional support

- Emotional support was part of interactions with patients accessing all parts of the trust services. This was achieved by calm clear communication.

Summary of findings

- Processes were in place to ensure that staff could access support following traumatic or difficult calls or attendances. Staff were observed providing immediate support to colleagues.
- External counselling and chaplaincy was available for staff to access.

Supporting people to manage their own health

- A frequent caller policy was in place to support regular service users affording them a frequent callers plan. However, trust monitoring systems were unable to track these patients and was unable to identify the number of patients with a frequent caller plan.
- Staff regularly enquired as to availability of patients own medications during interactions with patients.

Are services at this trust responsive?

Requires improvement

We have rated the trust as requires improvement for responsiveness. This is because:-

- Both Emergency care and EOC were rated as requires improvement. Both PTS and 111 services were rated as good.
- The processes for complaint response failed to meet expected targets. Complaints seldom acknowledged organisational responsibility and there was little evidence of learning from complaints.
- Organisational planning had not facilitated equal distribution of resource across the geographical area served.
- A 'tethering' system resulted in some patients waiting longer than necessary for emergency attendance.

Service planning and delivery to meet the needs of local people

- The trust was working closely with commissioners to plan services against the background of significant increases in demand.
- The trust included the presence of major areas of risk (airports, channel tunnel and M25) in its planning.

However, the HART team was only available 70% of the time due to staffing shortages. The CAD system also failed to identify HART incidents which could lead to the inappropriate dispatch of crews to such incidents.

- Day to day planning and optimum use of resources was facilitated by an ambulance tracking system.
- The trust worked with strategic clinical networks (SCN) and operational delivery networks (ODN) and also the trauma network to plan for complex care.
- Ambulance hours were not distributed evenly across the areas the trust served. This had led to variation in service and longer waits for some locations.
- Staff considered PTS planning to be unrealistic and not taking full account of urban density and weight of traffic.
- The trust worked collaboratively with its partner organisation for 111 service provision to plan services in line with patient needs.

Meeting people's individual needs

- The trust had suitable equipment and processes to support both the emergency and routine transfer of bariatric patients.
- The IBIS system allowed trust staff to identify and tailor treatment towards long term conditions and morbidities.
- A SMS system was in place allowing callers who have hearing impairments or physical disabilities to access 999 services. PTS services used a type talk system to support patients with hearing impairment.
- Arrangements were also in place to support callers for whom English was not their first language.
- Call handlers received training on engaging callers with dementia or mental health issues during induction. However, general dementia awareness training was not provided by the trust.
- PTS staff had advanced knowledge of care plans for dementia and learning disability patients allowing them to fully support them during transfer.

Access and flow

- The major inhibitor to access and flow was delayed handover at emergency departments. The ambulance service has limited influence on the causative factors. In

many cases handover significantly exceeded the 15 minutes target at all acute trusts and has led to a major loss of productive ambulance capacity. Although the trust had initiated the use of HALO staff within emergency units to support immediate handover, during the inspection we observed ambulances delayed on a number of occasions.

- By utilising paramedic practitioners with the skills to provide robust care support the trust had attained a 23% non-conveyance rate. The trust also had a higher rate of transfer to care provided by places other than acute hospitals.
- The trust did however utilise a tethering system whereby a vehicle is held back to attend potential RED1 or RED2 calls. This results in other calls waiting longer than necessary for attendance and had led to patient complaints.
- The patient reminder service for PTS was only used in 50% of cases. There was also a high number of aborted journeys (patient not available but PTS not informed), many of which were linked to discharge processes within the acute trusts.
- Clinician call back within ten minutes from the 111 service was significantly better than the national average.

Learning from complaints

- At the time of inspection the trust had 364 open complaints of which 200 were beyond the standard 25 day response time. There was no severity or thematic analysis of this backlog.
- When reviewing a sample of 25 complaints we identified poor quality of investigation with little clinical oversight.The trust referred to the majority of complaints as "unjustified". There was subsequently little evidence of learning from complaints

Are services at this trust well-led?

Inadequate

We have rated the trust as inadequate for well-led. This is because:-

- Emergency and urgent care services were rated as inadequate. EOC, PTS and the 111 service were rated as requires improvement .
- The board had numerous interim post holders. We saw evidence of inter-executive grievance.
- Roles and accountabilities within the executive team lacked clarity.

Summary of findings

- Risk management was not structured in a way that allowed active identification and escalation to the board.
- Staff reported a culture of bullying and harassment.

Vision and strategy

- In March 2015 the trust ratified a clinical strategy 2014-2019. The document was comprehensive providing a vision for service, a series of milestones and featured a number of strategic pledges to patients.
- Executive directors were assigned lead roles for each strategic pledge. However, during the inspection senior staff did not identify with this accountability.
- Review of minutes of board meetings from March 2015 to the date of inspection could not identify at which point the clinical strategy had returned to board for review. There was no form of measurement for the attainment of the strategy pledges. Furthermore, many of the concerns in our report can be linked directly to the non-delivery of the strategic pledges.
- The trust values of Pride, Innovation, Integrity, Respect and Responsibility featured on the trust website.
- During the inspection we interviewed many staff who did not recognise either the clinical strategy or the trust values. There was little evidence of transfer of strategic or behavioural intent through the organisation.
- A lack of engagement with staff with respect to the development of the trust values had contributed to a workforce feeling of not being listened to.
- This had led to the EOC developing its own set of values and a four point strategy that lacked explicit linkage to the trust clinical strategy.

Governance, risk management and quality measurement

- Board minutes did not appear to be clearly directed by actions with few requests for subsequent updates or further deep dive reviews.
- The trust had a board assurance framework (BAF) that linked strategic risk to strategic objectives.
- The BAF was due for review at the May 2016 trust board meeting and prior to that was updated in July 2015. The BAF was regularly reviewed at Audit Committee during 2016.

Summary of findings

- At the time of inspection the trust board had seven sub board committee meetings. The clinical quality working group, which reported into the Risk Management and Clinical Governance Working Group (RMCGC) had 13 further sub groups reporting in to it.
- Risk management processes were under developed. Staff told us that there were no set criteria for raising issues onto the risk register with no clear escalation criteria to ensure trust board sight. Risks managed at board level did not have robust and monitored action plans.
- Following the project to implement changes in the triage of RED2 and GREEN calls the commissioners initiated risk summit status and subsequently a full investigation in the governance of the project. The findings of the project were highly critical of governance processes at the trust.
- Governance processes did not identify, assess and manage issues relating to incidents and complaints until immediately prior to the inspection.

Leadership

- Following a recent external investigation into the management of change of processes for RED1 response the Chairman had resigned and the CEO was on extended leave.
- At the time of inspection the trust was led by an experienced interim chair.
- In a short period of time the chair has completed a diagnostic and has clear sight on required actions and key risks.
- The chair was supported by seven non executive directors of varying years of experience. During interviews they described the increasing need to become involved in operational functions over the last six months as a consequence of executive delivery failures. Voting non-executive directors outnumbered executive directors.
- The director of commissioning and deputy CEO had been appointed as interim CEO following the extended leave afforded the substantive CEO. The interim CEO described future processes for improving accountability, governance and engagement issues and we heard from some staff that communication had improved. However, some staff were critical of the credibility of this appointment as they considered the post holder associated with previous executive failings.

Summary of findings

- The COO was about to leave the trust to take up an appointment that enables further professional development. The trust has appointed a replacement.
- There is a lack of clarity regarding the respective roles of the three clinical directors within the executive team. This was notable with respect to involvement in and understanding of risk and serious incident management. The director of nursing lacked a clear portfolio.
- The paramedic director has successfully developed the paramedic workforce with a strong education and training strategy. Whilst this focus has clearly developed a cutting edge workforce, the implementation of clinical strategy and attainment of key performance indicators were not well articulated during our interview.
- The director of human resource is also a recently appointed interim (covering sickness absence) and the finance director is new to role. A company secretary had also been appointed within the last month.
- The trust has recently reviewed its process for Fit and Proper Persons Regulation. It now has clear processes for newly appointed directors and addressed appropriately any historic gaps. There was a process for annual declaration.
- The board was in a period of significant transition. The ability to operate as an effective unitary board was constrained by the degree of operational input that has had to be undertaken by non-executive directors, the number of interim positions and the lack of definition of the roles and accountabilities of executives, notably those with clinical responsibilities.
- During the inspection we saw evidence that there remains a number of inter-executive grievances outstanding. The presence of such issues amongst the trust leadership does not augur well for the formation of a successful team.
- Many staff indicated during our interviews that there was a lack of visibility of senior executives within the organisation.
- Local managers in many cases felt they did not have enough time, as a result of operational pressures, to complete managerial and governance functions.
- During the inspection we interviewed trust governors. They expressed serious concerns about the lack of communication with the trust board since recent board appointments.
- The governors interviewed felt there had been a lack of action relating to the concerns expressed to the executive.

Summary of findings

- The processes by which governors hold Non Executive Directors to account had not been developed. There was concern expressed about the use of informal communication routes with executives and non-executives.
- We did not identify any programme of board development during the inspection.

Culture and diversity within the service

- This was a complex and geographically spread organisation and as such varied culturally between counties.
- During our interviews with staff they demonstrated that they were exceptionally proud of the work they do and the positive impact they have on patient lives. The trust was above the national average for respondents to the 2015 national staff survey agreeing that there role makes a difference.
- However, many staff reported a culture of bullying and harassment. Much of these reports stemmed from style of contact and lack of support during sickness.
- Staff also attributed the bullying and harassment culture to the organisation drive towards attaining performance targets. In particular the pressure placed on middle and junior managers, many of whom have not had developmental support to deliver their role.
- The inability to ensure that managers apply HR policies in a consistent manner has led to a collective dispute relating to the transformation (workforce change) agenda.
- The 2015 NHS staff survey data indicated that the trust was worse than the national average for both staff feeling bullied and discriminated against.
- The trust had developed a culture of operating in a crisis by fire fighting, but a lack of step down process and medium and long term planning led to a lack of sustainable change.
- The trust has applied a 4% sickness trigger that may lead to exclusion from promotion. This trigger is reviewed on an individual case basis.
- The trust does not have an active health and wellbeing strategy.
- We heard concerns from a high number of staff during and after the inspection regarding the management of

sickness. We were provided examples where return to work had not been managed in a sympathetic way and due consideration to working practice adjustments had not been made.
- The trust completed the Workforce Race Equality Scheme (WRES)report for 2015. The document has been seen by the board along with a robust action plan. Plans have been shared with staff and trade unions.
- The trust has set equality objectives and makes an explicit link with patient outcomes and experience.
- The action plan was developed by the Inclusion Committee which reports to the board on matters of equality.The trust also had an active BME Staff Network.
- BME staff constitute 2.6% of the workforce which is below the 6.1% within the local population. The trust was aware of recruitment issues and was working with universities to enhance the recruitment of BME staff onto pre registration degree courses.
- BME staff were represented at all levels of the organisation with the exception of the trust board.
- The staff survey indicates that BME staff were less likely to be appointed from shortlisting than white staff and were more likely to enter into a formal disciplinary process.
- The experience of discrimination at work by a manager, and the view of not having opportunities for progression was high for both BME and white staff.
- However, the BME staff sample size for completion of the staff survey is small and casts a question of reliability on the WRES data.

Public and staff engagement

- The trust had actively sought to engage with the public notably with the development of community first responders.
- The trust held an annual survivors event for public, patients and staff to attend.
- The trust was utilising social media in an attempt to inform and influence the use of trust services.
- The trust held annual staff awards to acknowledge long service and individual and team excellence .
- The trust engagement score in the national staff survey had improved between 2014 and 2015 but still remained below the national average.
- Meeting structures and communication across the trust was not standardised and staff reported the receipt of 'mixed messages' from managers.

Summary of findings

Innovation, improvement and sustainability

- The trust had a positive culture of encouraging innovation. This was most notable in the development of the paramedic workforce and the introduction of critical care and advanced paramedics. The inspection team were highly impressed with this aspect of service and workforce development.
- Other areas of service had also introduced innovative practice including mental health triage and the implementation of the make ready stations.
- The trust had embarked upon a transformation programme to re-design the workforce to support both the new operational structure and the delivery of the clinical strategy. However, consultation had lacked clarity and implementation had been delayed. The impact of this was additional stress and uncertainty on the workforce.

Overview of ratings

Our ratings for South East Coast Ambulance Service NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Patient transport services (PTS)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
NHS 111 service	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Our ratings for South East Coast Ambulance Service NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Notes

Outstanding practice and areas for improvement

Outstanding practice

- The trust encouraged staff to take on additional roles and responsibilities and provided training and support to enhance the paramedic roles. The specialist paramedics' roles such as the critical care paramedic had expanded and developed.

Areas for improvement

Action the trust MUST take to improve

Action the location MUST take to improve

- Take action to ensure all staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns receive an appropriate level of safeguarding training.
- Take action to ensure all Emergency Operations Centre premises containing confidential data and critical equipment are secure.
- Take action to ensure the CAD system is properly maintained.
- Take action to provide every operational Hazardous Area Response Team (HART) operative with no less than 37.5 hours protected training time every seven weeks.
- Formulate a contingency plan to mitigate the loss of the Patient Transport Services control room in Dorking that will allow the service to continue.
- Take action to ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services.
- Take action to improve the reporting of low harm and near miss incidents.
- Take action to ensure that national performance targets are met.
- Take action to improve outcomes for patients who receive care and treatment
- Take action to adequately manage the risk of infection prevention and control. This includes ensuring consistent standards of cleanliness in the ambulance stations, vehicles and staff hand hygiene practices.
- Take action to ensure there are always sufficient numbers of staff and managers to meet patient safety and operational standards requirements. This should include ensuring there are adequate resources for staff to usually take their meal breaks, finish on time, undertake administrative and training.
- Take action to recruit to the required level of HART paramedics in order to meet its requirements under the National Ambulance Resilience (NARU) specification.
- Ensure that ambulance crews qualifications, experience and capabilities are taken into account when allocating crews to ensure that patients are not put at risk from inexperienced and unqualified crews working together
- Take action to protect patients from the risks associated with the unsafe use and management of medicines. This should include: appropriate use of patient group directives; the security and safe storage of both medicines and controlled drugs; the management of medical gas cylinders.
- Take action to ensure that patient records are completed appropriately, kept confidential and stored securely.

Action the location SHOULD take to improve

- Take action to review all out-of-date policies and standard operating procedures.

Outstanding practice and areas for improvement

- Develop procedures to ensure HART rapid response vehicles (RRVs) are relieved to attend HART incidents within the timescales set out in standards 08-11 of appendix three of the NHS service specification 2015-16: Hazardous area response teams.
- Take action to audit 999 calls at a frequency that meets evidence-based guidelines.
- Take action to put in place an effective and consistent process for feedback to be given to those who report incidents and develop a robust system for sharing lessons learned from incidents
- Take action to ensure all staff receive an annual appraisal in a timely fashion in order that they can be supported with training, professional development and supervision.
- Take action to address discrepancies in the number of funded ambulance hours with activity across the trust.
- Ensure all first aid bags have a consistent list of contents, stored securely within the bags.
- Devise a system that will accurately track the whereabouts of the PTS defibrillators.
- Include a question regarding the patient's DNACPR status at the point of each transport booking.
- Provide Mental Capacity Act and Deprivation of Liberty Safeguards training to all operational staff.
- Take action to engage staff in the organisations strategy, vision and core values. This includes increasing the visibility and day to day involvement ofthe trust executive team and board across all departments.
- Develop a detailed and sustained action plan to address the findings of the staff survey including addressing the perceived culture of bullying and harassment.
- Continue to take action to address the handover delays at the acute hospitals.
- Ensure there are adequate resources available to undertake regular audits and robust monitoring of the services it provided.
- Ensure that there is adequate access to computers at ambulance stations to facilitate e-learning, incident reporting and learning from incidents.
- Ensure there is a robust system in place to manage, investigate and respond and learn from complaints. This includes ensuring that all staff understand the Duty of Candour and their responsibilities under it.
- Ensure that there is appropriate trust wide guidance and training provided regarding attending patients with mental health problems. This should include reviewing the current arrangements for assessing capacity and consent.
- Ensure that there are structured plans in place for all frequent callers as per national guidance. The information regarding this should be collected and monitored as per national guidelines.
- Ensure that there are systems and resources available to monitor and assess the competency of staff. This includes ensuring they always involve patients in the care and treatment and treat them with dignity and respect.
- Ensure there are robust systems in place to ensure all medical equipment is adequately serviced and maintained.
- Ensure that vehicles and ambulance stations are kept secure.
- Ensure that there is sufficient time for vehicle crews to undertake their daily vehicle checks within their allocated shift pattern.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective governance arrangements in place. There were no effective assurance systems for auditing, monitoring or driving improvement in order to protect patients and staff from the health, safety and welfare risks from using the service.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not operate and implement, robust procedures and processes that make sure that people are protected from abuse. There were insufficient resources allocated, scrutiny or oversight of safeguarding within the trust.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

The provider had not have systems in place to ensure that the management and administration of medication met legislative and best practice guidance. In particular patients and staff were at risk because the use of patient group directives, security and storage of medicines were not safe.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have robust systems in place to ensure that that the equipment used was appropriately serviced, maintained and stored securely.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not always provide sufficient numbers of suitably qualified, competent, skilled and experienced persons to ensure that patients received a safe, appropriate and prompt response when calling for emergency services.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 34 Brighton & Hove City Council

Subject:		**Patient Transport Services (PTS) Update**
Date of Meeting:		**19 October 2016**
Report of:		**Executive Lead Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-5514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report presents the latest update on Patient Transport Services (PTS) following the introduction of a new contract in April 2016.

1.2 **Appendix 1** contains performance information provided by Sussex CCGs; **Appendix 2** contains the independent report on the PTS mobilisation.

2. RECOMMENDATIONS:

2.1 That HOSC members note the content of this update report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 A new contract for PTS was introduced in April 2016. Following a procurement process, the contract was awarded to an independent sector provider, Coperforma. The previous PTS provider was South East Coast Ambulance NHS Foundation Trust (SECAmb). The lead commissioner for this service is High Weald Lewes Havens CCG, although all seven Sussex CCGs are responsible for the contract.

3.2 From the outset there have been severe performance problems with contract performance. This has been considered at the past three HOSC meetings and information on recent performance is included as **Appendix 1** to this report. In recent weeks, as well as some continuing performance issues, there have been significant problems with PTS subcontracts, with two transport providers unexpectedly ceasing business, and allegations of unpaid wages. **Append ix 1** also includes information on these issues.

3.3 The contract mobilisation process was referred to independent review by Sussex CCGs. The independent report on this is included as **Appendix 2** to this report. A

further independent review of the procurement process is ongoing and will be reported to the HOSC when it becomes available.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 This report is to note so there are no alternative options to consider.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None in relation to this update report.

6. CONCLUSION

6.1 This is an update report.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 There are no financial implications to this update report.

Legal Implications:

7.2 There are no legal implications arising from this report.

Lawyer Consulted: Elizabeth Culbert Date: 27 September 2016

Equalities Implications:

7.3 None for this update report.

Sustainability Implications:

7.4 None for this update report.

Any Other Significant Implications:

7.5 None for this update report.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by Sussex CCGs

2. Independent report on PTS contract mobilisation

Documents in Members' Rooms

None

Background Documents

None

Sussex Non-Emergency Patient Transport Service – Health and Overview Scrutiny report

Current position

- Feedback from provider trusts whose patients use the service, and from patients themselves, is that the service is much improved from its poor start. However, we know that the improvement is not embedded across the whole of Sussex.
- In September drivers employed by Dockland Medical Services (DMS) arrived at work to find their work stations locked and the CCGs were informed that some staff had not been paid.
- This clearly unacceptable and we are grateful to staff who continued to make themselves available for work despite not receiving pay.
- Coperforma provided additional capacity to mitigate this loss of DMS and hospital Trusts informed the CCGs that this situation did not impact on the service.
- The CCGs have been speaking regularly to Coperforma and the unions to fully understand the situation and in view of this dialogue the GMB stood down their planned strike action.
- The CCGs have worked with Coperforma and the unions to put in place a mechanism coordinated by the GMB to pay DMS staff any outstanding payments via a third party payroll.
- The CCGs continue to work with Coperforma and the unions to find a solution for DMS staff.
- CCGs are utilising the powers available within the NHS standard contract and enacting these where Coperforma's performance falls below what is expected.

Since the last meeting:

Patient safety

- Patient safety is our priority and the CCGs have established a Patient Safety Group, led by a GP, with representatives from HealthWatch, local authority safeguarding, hospital Trusts to oversee patient safety and experience.
- Members of the group have been visiting hospitals, in particular renal departments, speaking to patients and front line staff to get their feedback on the service.
- This work programme is continuing; the team will next visit oncology departments.
- These visits so far indicate that the physical health of patients has not been harmed by the problems with the transport service. However, too many patients have suffered stress at what is already a difficult time in their lives, and for that we are very sorry.

Issues between Coperforma and some of its contractors

- Some Sussex CCGs received an email early in September from a number of contractors saying that they had not been paid for work they had done for Coperforma.
- The status of this email was unclear; it was unsigned, came from a generic email account, and three of the organisations listed as a signatory have since informed us that they had not consented to their inclusion.
- We facilitated a meeting between Coperforma and Docklands Medical Services (DMS), and have now been informed by DMS that they have received the money owing to them.

Performance

- The feedback we are receiving from patients and staff tells us that the service has improved since April. The latest patient user survey shows patient satisfaction at 4.1 out of 5.

- Coperforma sends us regular reports on its performance and their figures show that around 9 out of 10 patients are getting to hospital and home again within the performance targets set out in the contract.
- Although the improvements are still not Sussex-wide.
- CCG and CSU representatives met with Coperforma to understand in detail how their performance reporting operates and how raw data is extracted and handled to generate the performance reports. This has identified some data anomalies which require Coperforma to investigate and respond.

Maintaining improvements

Summary of actions and improvements taking place:

- New Transport Providers added to the transport framework and introduced into Sussex.
- Formation of a 'High Acuity Team' to oversee the transportation of priority patient groups, including renal, oncology, and frail patients and those travelling to specialist hospitals in London
- Phased implementation of Operational Zones for the booking, dispatch and delivery of transport across Sussex.
- Continued use of dedicated private ambulances by Acute Trusts to manage and maintain hospital patient flow.
- Implementation of the local service development improvement plans.
- Coperforma working with transport providers to enforce professional standards.
- Engagement with Healthwatch and Patient Forum to assist with building public and patient confidence in PTS and gain patient feedback.

TIAA Report

- Since the last Health and Overview Scrutiny Committee meeting the independent investigation report compiled by TIAA, reviewing the adequacy of the mobilisation arrangements for the new Patient Transport Service contract has been released.
- It was shared with the Sussex CCG Governing Bodies throughout July and stakeholder groups in early August, before it was released into the public domain.
- The report makes 10 recommendations. An update on each is presented in the attached appendix.
- The Sussex CCGs, procurement and commissioning teams have committed to adopt the learning from the report for future procurements and have acted on the recommendations that pertain to the current transport service contract.

However, separately from the TIAA report, allegations came to light concerning potential irregularities in the booking and despatch of patient transport, which are being investigated.

Specialist advisor

- The TIAA report recommended that we recruit a transport expert to oversee the contract.
- A Specialist Advisor has been recruited who is working with the CCGs and Coperforma to review the accuracy of the data, assess the sustainability of the current service, and ensure that improvements to date are maintained.

Contingency plans

- The CCGs continue to monitor the PTS situation closely and have / are developing contingency plans based on scenario planning to enact should anything happen that may adversely impact on service delivery.

Appendix

Rec.	Recommendation	Priority
1	An independent patient transport service specialist be considered to support the CCG to oversee Coperforma's remedial action plan and service resilience until the PTS is operating as 'Business as Usual' **Management Update: Agreed. Following a competitive interview process the CCG appointed Derek Laird on a six month contract with effect from 30th August 2016 to provide specialist PTS support. Derek has a wide range of experience within PTS provider organisations at a senior level and has direct experience of PTS contract mobilisation.**	1
2	Each of the Trusts in Sussex be requested to identify additional costs they have incurred and submit theses to HWLH CCG for contractual discussion with Coperforma. **Management Response: Agreed. All provider organisations have been requested to submit details of additional transport costs incurred directly for reimbursement by Coperforma. All organisations with the exception of Brighton and Sussex University Hospitals NHS Trust have responded to this request. Coperforma have been advised to provide for costs from BSUH at c£80,000 per month.**	1
4	Consideration should be given to establishing whether there are grounds for financial recovery due to the contract failure in terms of number of journeys not properly delivered during April and May 2016. **Management Response: Agreed. The full contract is with Blake Morgan for review to ensure that the terms and conditions of the contract are enforced in full. A further update will be available once this review is complete and action considered and agreed by the CCG.**	1
8	Contingency arrangements be built into the planning process for major contracts where significant service changes are anticipated. **Management Response: Agreed. This recommendation is being shared with South East CSU and South of England Procurement who provide specialist advice to Sussex and East Surrey CCGs. Derek Laird has been asked to develop short term and long term contingency arrangements in the event that the current contract is terminated by the Provider or Commissioner prior to its end date.**	1
3	Consideration should be given to establishing whether there is legal entitlement to recover CCGs additional costs arising from Coperforma's failures of contract performance. **Management Response: Agreed. The full contract is with Blake Morgan for review to ensure that the terms and conditions of the contract are enforced in full. A further update will be available once this review is complete and action considered and agreed by the CCG.**	2

Rec.	Recommendation	Priority
5	The terms of reference for any mobilisation Board or similar be agreed at the first meeting. **Management Response: Agreed. This recommendation is being shared with South East CSU and South of England Procurement who provide specialist advice to Sussex and East Surrey CCGs.**	2
6	Failure to attend key mobilisation meetings should be noted and escalated appropriately (internally and externally). **Management Response: Agreed. This recommendation is being shared with South East CSU and South of England Procurement who provide specialist advice to Sussex and East Surrey CCGs**	2
7	Legal advice be taken to confirm that the tender and contract documentation can make it explicitly clear that the signature of the appropriate person from the lead CCG is legally binding and signatures from the other participating CCGs are not required before contract mobilisation can commence. **Management Response: The CCG understands that a Collaboration Agreement signed by CCGs participating in procurements provides the necessary governance framework for lead CCGs to sign service contracts on behalf of associate CCGs once individual GB approval of contract award is made. The CCG will share this recommendation with South East CSU and South of England Procurement who provide specialist advice to Sussex and East Surrey CCGs to ensure Collaborative Agreements and the contract signature process are more clearly expressed during the procurement process.**	2
9	Consideration should be given to including within the contract specification for major contracts where significant service changes are anticipated that a phased transition approach by bidders would be welcomed. **Management Response: Agreed. . The CCG will share this recommendation with South East CSU and South of England Procurement who provide specialist advice to Sussex and East Surrey CCGs.**	2
10	Consideration be given to commissioning independent consultants to monitor and advise on the mobilisation for major contracts where significant service changes are anticipated. **Management Response: Agreed. . The CCG will share this recommendation with South East CSU and South of England Procurement who provide specialist advice to Sussex and East Surrey CCGs.**	2

NHS HIGH WEALD LEWES HAVENS CLINICAL COMMISSIONING GROUP

Adequacy of the mobilisation arrangements for the new Patient Transport Service contract

June 2016

Adequacy of the mobilisation arrangements for the new Patient Transport Service contract

Executive Summary

INTRODUCTION

1. TIAA has carried out a review into the adequacy of the mobilisation arrangements for the new NHS Non-Emergency Patient Transport Service contract (PTS contract) which became effective from 1 April 2016. The review was commissioned by NHS High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG) on behalf of the Sussex CCGs.

SUMMARY

2. The new PTS contract was clearly not successful in delivering the required level of service during April and early May 2016, the period covered by this review. A summary of our work in relation to the adequacy of the mobilisation arrangements is set out below:

Consideration of the transition arrangements set out in the contract specification, the tender submission, and the signed contract; and the extent to which compliance with these can be evidenced.

Assessment: The new PTS contract was not simply a case of a straightforward change of provider, but rather was the introduction of a new delivery model reflecting stakeholder and user feedback. There was a detailed and jointly agreed mobilisation transition plan, on which the CCGs received written and / or verbal assurances, of delivery against milestones. The monitoring arrangements put in place by the Sussex CCGs during the mobilisation period did identify potential issues which indicated that Coperforma may not be fully ready to deliver the service on 1 April 2016. However, Coperforma provided positive assurances that the mobilisation stage would be fully completed by 1 April 2016.

The handover arrangements from South East Coast Ambulance Service (SECAmb) to Coperforma that were agreed with the Sussex CCGs, and the extent to which compliance with these can be evidenced.

Assessment: The handover arrangements required a balance between SECAmb being able to continue to deliver the PTS service up until the handover day and the requests from Coperforma for the transferring staff to be released for training. We suggest that this is not unusual in a TUPE situation and Coperforma should have ensured there were appropriate mitigating actions in their mobilisation plan. The data requests from Coperforma were processed by the Patient Transport Bureau (PTB) and not SECAmb and consequently we do not consider the handover process from SECAmb to Coperforma to have resulted in insurmountable issues that could not have reasonably been expected to be addressed by Coperforma during this period.

Sample check of cases of non-performance by Coperforma to assess whether these were as a result of failures in the mobilisation and handover arrangements, or whether there were other factors which gave rise to these failures.

Assessment: From the information which has been provided to us it is clear that issues of non-performance were not limited to the initial start-up of the contract. It is clear that Trusts receiving patients have been assisting in mitigating some of the non-performance issues beyond the initial start of the contract, and that without this assistance the actual position during April 2016 would have been significantly worse. The fact that there were new

complaints being received by the CGGs, and formal incidents were being recorded by all of the Trusts during the third and fourth week of the contract indicates there may be underlying issues, rather than mobilisation-related issues that have yet to be fully addressed.

Establishing the reasons for the failure of the service delivery on commencement of the new contract by Coperforma, and whether these could have been reasonably anticipated prior to the contract commencement date.

Assessment: The processes put in place by Coperforma were markedly different to those operated previously by SECAmb and the PTB. We have examined the initial reasons stated by Coperforma as being the two principal causes of the poor performance, (high volume of calls and errors in the live data transferred), and we suggest both should have been capable of being addressed in a number of days, rather than weeks. The fact that significant service delivery issues were still being experienced six weeks after the contract start date therefore suggest that there were other reasons for the poor service delivery. Our findings indicate that the poor service delivery was a combination of a number of factors and that individually each of these factors would have been unlikely to cause such poor performance. It is therefore the combination of these factors which created the situation whereby on 1 April 2016 Coperforma had an insufficiently tested Sussex-wide infrastructure which was expected to be able to seamlessly bed in after the contract start date without any adverse impact on service delivery. Any concerns Coperforma may have had immediately prior to 1 April 2016 with these factors either individually or collectively on their readiness to deliver the PTS service were not raised with HWLH CCG. The combination of key factors which indicate the arrangements had not been bedded in are listed below in no priority order:

- **Data transfer of demand modelling:** The migration from a primarily paper-based system to a technology-based system required significant data analysis to determine future demand and capacity patterns. The data transfer for this was direct from the PTB to Coperforma, as the CCG was not authorised to have access to the data. Due to issues with the quality of data Coperforma was unable to use the data for level of detailed demand modelling they have anticipated. However, Coperforma did not formally raise this as a significant issue with the CCGs that this was a potential no-go for going live. The reasons for this was that Coperforma had anticipated their contingency cover would have accommodated peaks in demand and capacity.
- **Advance Modelling of likely demand patterns:** It is clear from the information we have been provided with that the opportunity to fully utilise historic data for advance modelling cannot have been utilised effectively to identify the potentially competing demands of the geographically dispersed Trusts.
- **Field testing of system prior to 1 April 2016:** We would expect there to have been comprehensive testing by Coperforma and its sub-contractors prior to 1 April 2016. We suggest such testing could have highlighted some operational issues which would have enabled an interim solution to be put in place on 1 April 2016 to mitigate their impact. Coperforma has verbally advised us that field testing was carried out, but we have not been provided with any supporting evidence on the nature and extent of their testing of the system across Sussex and with multiple Trust locations. We are therefore unable to comment on the adequacy of any field testing of their system.
- **Parallel running during mobilisation period:** It is clear that the intention set out in Coperforma's Mobilisation Plan of effectively running parallel to the PTB in the three month period prior to April 2016 was not achieved.

- **Commissioning of hub offices:** The hub offices at Durrington and Eastbourne were not ready for use until very shortly before the start of April, which was several months behind the schedule set out in Coperforma's mobilisation plan.
- **Drivers' access to Mobile Work App via PDA:** There was a 72% increase in the number of PDAs being used between the start and end of April which suggests there were insufficient in place at the contract start date.
- **Data Transfer of journeys required post 1 April 2016:** As this matter is subject to a separate investigation we have only been provided with limited data by Coperforma and we are therefore unable to establish the extent of these errors, the impact of this on service delivery in April 2016, or indeed how swiftly these errors were identified and removed.
- **Number of calls:** The records indicate there was a significant increase in the number of calls made to Coperforma during the first week of the contract. We suggest it would not have been unreasonable to expect an increase in calls at the start of a new contract and that appropriate resilience arrangements would have been made. However the number of actual calls was higher than we suggest could have been reasonably expected and this increase also was exacerbated by Coperforma's staff spending longer than planned in reassuring callers and as well as the knock-on impact of the failures in other areas of the service delivery.
- **Roll out of the online booking facility:** The opportunity to train up an adequate number of staff at the Trusts to make on-line bookings which would have assisted in reducing the number of calls was missed as evidenced by there being only 88 log-in rights on 1 April 2016 which had increased to 1,468 by the middle of May 2016.
- **Previous experience of mobilising for a similar size Patient Transport Service Contract:** Previous experience of commissioning a similar Patient Transport Service contract in terms of scale and complexity should have provided for a tried and tested mobilisation process and timetable which would then have identified and assessed in a timely manner the cumulative effect of slippages on being ready for the 1 April 2016. Prior to being awarded the Sussex PTS contract Coperforma's experience of delivering patient transport was through a number of significantly smaller value contracts.

The appropriateness and timeliness of the actions taken by HWLH CCG and Coperforma

Assessment: Poor performance and service issues impacting on patient experience and the delivery of the PTS were identified very quickly by both Coperforma and HWLH CCG. Once it became evident that the problems were not going to be rectified within a short number of days Sussex CCGs put in place arrangements designed to constructively assist Coperforma to improve its service delivery. HWLH CCG remained focussed that any remedial actions taken by the CCGs must not inadvertently further jeopardise patients being collected and delivered on time.

Any lessons learned which could be incorporated into other future major contracts let by HWLH CCG.

Assessment: There are number of lessons to be learned for future major projects which entail significant change in how the service will be delivered. The key lessons include:

- Engage a suitable independent professional consultant to oversee the technical aspects of the service.
- Ensuring there is a 'Plan B' (contingency plan) in place for all major procurements.

- Utilising a phased implementation where possible on any major procurements where there are significant changes to the contract and/or the service delivery model.
- Need to have in place a robust monitoring process to provide independent assurance to both the CCGs and the new provider that services will be ready to operate in accordance with the contract specification from the first day of the contract. e

CONCLUSION

3. The Sussex CCGs took a constructive dialogue approach to engaging with Coperforma during the PTS mobilisation process, an approach which has been successful on other contracts. The period of time between contract award and contract mobilisation was not unreasonable when compared with other patient transport services contracts let by other CCGs, however there appears to have been a slower than originally intended start by Coperforma which provided less time to demonstrate they were going to be ready to fully deliver from 1 April 2016. From the information we have been provided with, Coperforma was clearly very positive and confident throughout the mobilisation process that there would be a seamless and successful transition on 1 April 2016 without the need for any phased/staged transfer. Given the resulting failure to meet the required service standards, which were still not being met six weeks later, this confidence would appear to have been misplaced. Coperforma has advised us verbally that despite slippages in their timetable as set out in their original mobilisation plan they did not raise any major concerns about being fully ready for 1 April 2016. We consider that patient welfare needed to be the paramount consideration in any decision to confirm readiness to deliver.

4. We suggest that there are a number of factors which collectively created a situation whereby there was an insufficiently tested Sussex-wide infrastructure which was expected to be able to seamlessly bed in after the contract start date without any adverse impact on service delivery. Without a period of parallel running prior to the contract start date the potential impact on service delivery and patient welfare of the combination of these factors, which can be now be seen in hindsight, would not have been so evident in the immediate run up to the contract start date. The service delivery issues subsequently experienced during April and May 2016 and in particular the failure to adequately factor in the conflicting demands of simultaneously servicing six Trusts from the first day of the contract indicates Coperforma should have been less confident and should have considered making a request to the CCGs that a phased implementation be considered, even if this was only days before 1 April 2016.

5. When adopting a constructive dialogue approach to future service changes, the Sussex CCGs may wish to consider requiring more tangible evidence of preparedness from providers (especially new ones) rather than accepting written and verbal assurances. HWLH CCG does not employ a professional patient transport expert, and it would have been appropriate to consider engaging one to oversee the mobilisation process for a contract of this scale and complexity. This expertise would also provide the critical independent friend role that we suggest would have benefited both the CCGs and Coperforma, and they would have been able to identify whether the confidence of Coperforma was demonstrably underpinned by supportable and sustainable evidence.

ACKNOWLEDGEMENT

6. We would like to thank staff and management from all the CCGs in Sussex, Coperforma, as well as local Trusts and SECAmb for their co-operation and assistance during the course of our work.

Recommendations

Rec.	Recommendation	Priority
1	An independent patient transport service specialist be considered to support the CCG to oversee Coperforma's remedial action plan and service resilience until the PTS is operating as 'Business as Usual'	1
2	Each of the Trusts in Sussex be requested to identify additional costs they have incurred and submit theses to HWLH CCG for contractual discussion with Coperforma.	1
4	Consideration should be given to establishing whether there are grounds for financial recovery due to the contract failure in terms of number of journeys not properly delivered during April and May 2016.	1
8	Contingency arrangements be built into the planning process for major contracts where significant service changes are anticipated.	1
3	Consideration should be given to establishing whether there is legal entitlement to recover CCGs additional costs arising from Coperforma's failures of contract performance.	2
5	The terms of reference for any mobilisation Board or similar be agreed at the first meeting.	2
6	Failure to attend key mobilisation meetings should be noted and escalated appropriately (internally and externally).	2
7	Legal advice be taken to confirm that the tender and contract documentation can make it explicitly clear that the signature of the appropriate person from the lead CCG is legally binding and signatures from the other participating CCGs are not required before contract mobilisation can commence.	2
9	Consideration should be given to including within the contract specification for major contracts where significant service changes are anticipated that a phased transition approach by bidders would be welcomed.	2
10	Consideration be given to commissioning independent consultants to monitor and advise on the mobilisation for major contracts where significant service changes are anticipated.	2

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

RELEASE OF REPORT

7. The table below sets out the history of this report.

Date working draft report issued:	27 June 2016
Date draft report issued:	1 July 2016
Date revised draft report issued:	13 July 2016
Date management responses recd:	19 July 2016
Date final report issued:	19 July 2016

Detailed Findings

SCOPE AND LIMITATIONS OF THE REVIEW

8. The review included consideration of the robustness and transparency of the mobilisation arrangements for the seamless transition of the Non-Emergency Patient Transport Services (PTS contract) from the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) to Coperforma. TIAA was commissioned by the CCG's Chief Finance Officer in April 2016 to carry out this investigation review. The scope of the review included:

- Consideration of the transition arrangements set out in the contract specification, the tender submission, and the signed contract; and the extent to which compliance with these can be evidenced.
- The handover arrangements from SECAmb to Coperforma that were agreed with HWLH CCG and the extent to which compliance with these can be evidenced.
- A sample check of cases of non-performance by Coperforma to assess whether these were as a result of failures in the mobilisation and handover arrangements, or whether there were other factors which gave rise to these failures.
- Establishing the reasons for the failure of the service delivery on commencement of the new contract by Coperforma, and whether these could have been reasonably anticipated prior to the contract commencement date.
- The appropriateness and timeliness of the actions taken by HWLH CCG and Coperforma.
- Any lessons learned which could be incorporated into other future major contracts let by HWLH CCG.

9. The scope of the review did not include consideration of the tender evaluation and award process unless it directly impacted upon the mobilisation arrangements. This review does not consider: any due diligence work carried out on Coperforma or its transport sub-contractors; the contract specification; or the changes in eligibility criteria. The integrity and completeness of data provided by Coperforma to HWLH CCG is outside the scope of this review. This review has only considered the actions taken by the CCGs, the Trusts and Coperforma to 15 May 2016.

10. Since this review was commissioned HWLG CCG has also commissioned TIAA to review the procurement process. The decision to carry this out as a separate review was to avoid any delays in the issuing of this report on the adequacy of the mobilisation arrangements.

11. The following matters limited our work:

- We were unable to interview the Business Unit Manager for Coperforma, who was heavily involved with the mobilisation, as this person had left the employment of the company.
- We were unable to meet with two previous Programme Managers who were employed by Coperforma as they have since left the employment of this company.
- We have not reviewed the arrangements in place with the Coperforma's sub-contracted transport providers, and we have not interviewed any of these providers.
- We were unable to meet with the Head of the Patient Transport Bureau (PTB), who was heavily involved with the mobilisation.
- We have been unable to have sight of data held by the PTB prior to the data being transferred to Coperforma.
- We have only had limited access to data held by Coperforma which has not enabled us to independently verify the issues relating to the data integrity.
- There is a separate investigation commissioned by HWLH CCG into the patient live data transfer to Coperforma and to avoid compromising this investigation the data transferred has not been examined as part of this review.

12. There has been considerable press coverage both during the mobilisation and after the contract commencement date. We acknowledge that the press coverage has drawn attention to a number of problems being experienced with the PTS contract. We have not investigated any individual cases raised in these articles, or approached any of the press bodies, thereby ensuring that this press coverage has had no influence on our review. We cannot therefore comment as to whether collectively the press coverage has provided a balanced picture of the issues surrounding the service delivery problems experienced with the PTS contract.

BACKGROUND

13. The PTS is a Sussex-wide service that helps people access healthcare appointments. It is a non-emergency transport service, and is separate from emergency and other ambulance services. The service provides transport for eligible people who are unable to use public or other transport owing to medical conditions.

14. Sussex is part of the South East region that is characterised by its lack of very large cities, and instead has several regional hubs and market towns. The area of Sussex covers 934,900 acres, based on 1991 statistics, and a population in excess of 1.5 million. Within Sussex there are four Acute Trusts, a specialist hospital Trust, a Mental Health Trust and a Community Trust each of which require patient transport services.

15. Patients are transported via pre-booked journeys to and from Trusts, seven days a week, including Bank Holidays. The service is for people who meet certain medical criteria that would otherwise prevent them from getting to their appointment. The PTS is free at the point of use for all eligible patients. HWLH CCG has stated that the PTS provides "some 25,000 journeys per month for people who meet certain medical criteria that would otherwise prevent them from travelling to their appointment, and is free at the point of use".

16. The previous PTS contract was awarded to SECAmb by the Primary Care Trust (now disbanded) and was for a three year period and covered 1 April 2012 to 31 March 2015. The

contract was to provide the journey planning, dispatch and transport elements of the PTS. A separate journey booking service was provided by the Patient Transport Bureau (PTB). The PTB was directly managed by HWLH CCG and all PTB staff were employed by HWLH CCG.

17. SECAmb informed the seven CCGs in writing on 19 March 2014 that they did not wish to continue with the contract from 1 April 2015 under the existing terms and conditions. On 13 January 2015, SECAmb and the CCGs signed a one year extension to the PTS contract to cover the period 1 April 2015 to 31 March 2016 to enable the seven CCGs to undertake a robust and widespread review of NHS Patient Transport across the county and develop the service for future users.

18. The contract specification was drawn up following extensive stakeholder engagement. Consequently, a straight replacement of the existing service specification was not considered to be appropriate. There were a number of material changes made to the service delivery arrangements by the CCGs, and the key ones which impact upon the mobilisation are summarised below:

- The service was transferring from two organisations (PTB and SECAmb) to a single fully accountable organisation.
- The organisations providing the actual patient transport vehicles and drivers have to be separate legal entities in which the successful provider has no involvement.
- Some of the eligibility criteria for being able to use the PTS for renal patients were changed, and these became effective on the contract start date.
- The Key Performance Indicators included in the new contract were set at a higher level than those in the SECAmb contract.

19. On 1 April 2016, following a procurement process, responsibility for providing the PTS for Sussex was taken over by Coperforma. Coperforma is a private limited company based in Hampshire. Journey bookings and patient enquiries are dealt with by staff at Coperforma's Demand Centres in Eastbourne in East Sussex, Durrington in West Sussex and Thruxton in Hampshire.

20. The transport services themselves are provided by other independent organisations under sub-contract agreements with Coperforma. The ambulance providers include Thames Ambulance Group, VM Langfords, PTS24/7 and a variety of other transport providers, including specialist ambulance and wheelchair-accessible vehicle providers, and voluntary and community providers who are available 'on tap' to meet fluctuating demand.

21. The contract award was made at the end of November 2015, which was four months before the actual contract start date. The key dates in the contract award process are summarised (Table 1) below:

Table 1 – Key Dates in the contract award process

Item	Date	Weeks before live date
Contract Award	23 November 2015	19
Commencement of Mobilisation (PTS Transition meeting)	26 November 2015	18
Contract Signature (HWLH CCG)	23 December 2015	14
Contract Signature (Coperforma)	23 December 2015	14
Contract Signed by all CCGs	28 January 2016	9

22. Within the first few days of April 2016 it became evident to the CCGs that there were significant service delivery issues with Coperforma's delivery of the new PTS. There were a number of concerns raised publicly during the first month of the delivery of the service which indicated the transfer and mobilisation may not have not been seamless. This included cases cited in the local and national press of missed appointments due to failures to collect patients.

23. TIAA was commissioned by HWLH CCG to carry out this review to establish the extent of any failures in the robustness and transparency of the mobilisation arrangements for the seamless transition to Coperforma. At the time we were commissioned it was presumed that the service delivery issues solely related to initial mobilisation issues, and that these would have been fully rectified before completion of our review.

24. It has been difficult to obtain an accurate assessment of the actual performance during April and the first half of May 2016, and we have had to rely upon the performance figures provided by Coperforma to provide us with an overview (Table 2) below.

Table 2 – Key Performance Indicators (KPIs) reported by Coperforma

Performance Indicator	Target	Actual 8 April 2016	Actual 22 April 2016	Actual 13 May 2016
% of calls picked up within 60 seconds	95%	66%	72%	42%
% of renal patients to arrive between 45 mins before and the actual appointment time	100%	50%	55%	82%
% of renal patients to depart no later than 60 mins after booked time	100%	24%	21%	59%
% non-renal patients to arrive between 75 mins before and the actual appointment time for attendances	100%	22%	55%	81%
% non-renal patients to depart no later than 60 mins after booked time for attendances, 90 mins for planned discharges, and 180 mins for unplanned discharges	100%	32%	32%	43%

25. It is clear that the initial service delivery issues were not quickly resolved, and on 25 May 2016 the CCGs issued a letter to patients which advised that "The overall standard of the PTS managed by Coperforma Ltd has not been acceptable since its launch on 1 April 2016 and has fallen short of both the CCGs' and Coperforma's expectations in terms of overall patient experience. The service has experienced a series of operational issues that have impacted on the booking function, with patients and staff not being able to access phone lines in a timely way, and delays to transport provision, with patients not being picked up at agreed times and/or arriving at hospitals and clinics after the scheduled time of their appointment".

FINDINGS

Area: The transition arrangements set out in the contract specification, the tender submission, and the signed contract; and the extent to which compliance with these can be evidenced.

26. The following matters were noted from the work carried out during this review:

Contract specification

26.1 The NHS Standard Contract 2015/16 Particulars for the Non-Emergency Patient Transport Services (NEPTS) for Sussex - Service Specification which was developed by the Sussex CCGs, sets out the criteria and the framework for the delivery of all aspects of the NEPTS. The schedules within the contract outline the requirements and actions to be carried out by both the CCGs and successful tenderer. Consideration of the appropriateness of this Standard Contract for the PTS for Sussex is outside the scope of this review.

Tender submission

26.2 The tender submission was received from Coperforma on 22 September 2015. Within the tender submission was a Sussex Non-Emergency Patient Transport Contract Mobilisation Plan whereby Coperforma had stated that they have significant and proven expertise in implementing an effective and thorough mobilisation plan. A Risk Statement was included which set out Coperforma's approach to managing the identified mobilisation risks. An initial Risk Register set out 12 risks and how these would be mitigated.

Transition arrangements - mobilisation plan

26.3 An initial mobilisation plan was included within the contract under 'Schedule 2-H. Transition Arrangements' which listed 72 actions (dated 14 December 2015).

26.4 We have been advised that the mobilisation requirements as set out in the contract specification were drawn up by Coperforma's original Programme Manager and that they were based upon Coperforma's understanding of what actions would be necessary during the mobilisation period. It was further advised that the Programme Board requested that Coperforma work in conjunction with the CCGs to expand this Mobilisation Plan and consequently, a more comprehensive document was provided to the Programme Board in January 2016 by Coperforma's second Programme Manager.

26.5 The most recent mobilisation plan has 423 actions listed. We have been advised that HWLH CCG had input to the updated plan. We have been unable to compare the original plan to the most recent plan as the actions required are significantly different.

Commencement of mobilisation

26.6 In November 2015 HWLH CCG website advised that "The Sussex CCGs will be working closely with local people, the current service providers (including SECAmb and the PTB), Coperforma, and local NHS Trusts over the next four months to ensure a smooth transition to the new service from 1 April 2016".

26.7 Whilst the contract was signed by HWLH CCG and Coperforma on 23 December 2015 we understand that Coperforma was not prepared to commence the actual mobilisation arrangements until the contract had also been signed by the other six CCGs. The last signature was obtained on 28 January 2016. Coperforma has advised us that this did not adversely impact on their mobilisation arrangements.

26.8 In February 2016 Coperforma issued a statement advising that "Coperforma is working closely with the CCGs and NHS providers, together with community groups and charities across Sussex, to ensure a smooth transition to the new service and the

company is looking forward to delivering a transport service from 1 April 2016 that meets the needs of both patients and the NHS".

Mobilisation monitoring arrangements - Programme Board

26.9 A Programme Board was established to govern the procurement and transition phase. The Board's key duties and responsibilities being to monitor the mobilisation plan and take responsibility for the risk register. The Board consisted of four members representing the seven CCGs plus the Coperforma and the CCGs Project Managers. It was the responsibility of the CCG representatives to report back to their various Governing Bodies.

26.10 On 15 December 2015 the initial mobilisation plan was revised and was jointly agreed between Coperforma and the CCGs. Any further updates were to be approved by the Programme Board. The agendas for the Programme Board include a section on mobilisation, with an accompanying presentation provided by Coperforma outlining a high level summary of updates to the plan, which included a section on risks and issues.

26.11 Prior to Coperforma participating in the Programme Board a 'Risk and Issue Log' was maintained by the Project Manager of the Sussex Collaborative Delivery Team (SCDT) and shared with the Project Team. Ownership of the Risk and Issue Log transferred to the Coperforma Project Director once Coperforma joined the Programme Board in January 2016. Although a Risk Log was presented within Coperforma's tender submission mobilisation plan which highlighted 12 risks, it is not evident that these initial risks identified by Coperforma were actually transferred to the ongoing Risk and Issue Log.

26.12 Coperforma attended three mobilisation meetings between contract award and 31 December 2015 with representative from the CCGs, SECAmb and PTB. They first met with the PTS project team on 5 January 2016 and joined discussions at the 14 January 2016 meeting of the Programme Board when its Terms of Reference were redrafted to reflect their membership. These were formally agreed at the 10 March 2016 meeting, three weeks before the live date.

26.13 A review of the documented minutes provided for the Programme Board highlighted that attendance levels at the meeting declined from the initial meeting to the last meeting on 24 March 2016, one week prior to the live date, where the only representative for the seven CCGs was the HWLH CCG representative. A total of 20 action points were raised at this meeting, including actions such as ensuring there was access through the Trusts' firewalls for Coperforma's booking system. The need for the Trusts to validate Coperforma's site list to ensure nothing has been missed was raised as Coperforma had not been made aware of all of the Trusts' sites. An action point was raised for the Trusts' Chief Operating Officers to ensure Coperforma had been provided with a listing of all the Trusts' sites. It is a concern that this was five working days before the go-live date.

26.14 We have been advised by HWLH CCG that the CCG ensured that during the procurement, transition and mobilisation phases of the PTS project all issues and actions, both material and small were captured and collated, hence the volume. The 20 action points listed at the meeting on 24 March 2016 were discussed and assigned to appropriate leads for action. Most of these points were not 'mission critical' to a successful PTS go live, but necessary to capture to ensure good governance and effective ongoing productive operational delivery once the service was live. The actions

can be broadly themed into those relating to: 'IT preparedness', 'workforce and training' and 'transport provision'.

26.15 Whilst there are examples of Risk and Issue Logs being presented at various meetings and Boards, the content, risks and updates vary with no clear trail of how they are connected, nor how risks were noted as closed. In some instances, it is noted that actions from the Programme Board included updating the Risk and Issue Log, however, there was no evidence that the risks were included in the subsequent Risk and Issue Log.

26.16 HWLH CCG has advised that there were concerns around the level of IT readiness, in terms of the Trusts' firewalls allowing access to the Coperforma's PCS system and the Trusts' staff receiving training to enable them to access and use the on line booking system. The CCG took the action at the Programme Board to escalate these issues via the Trust PTS IT and generic PTS leads, and copied in the Chief Executive of each of the Trusts stating the required actions they needed to implement. Following this, assurance was received that the firewall issues were resolved.

26.17 With regard to training of Trust staff to utilise the new online booking system, the CCGs were assured with Coperforma's mitigating action which was to establish an overlay team to provide additional call centre capacity to compensate for staff not using the on line booking system immediately.

26.18 There was no independent specialist appraisal of the capabilities of Coperforma's systems and software to deal with the volume and range of demands which were likely to be placed upon them by the Sussex contract.

Mobilisation monitoring arrangements – Weekly Highlights Report

26.19 Coperforma was expected to provide weekly highlight reports detailing how they were delivering the key milestones outlined in the mobilisation plan. We have only obtained evidence of four such 'weekly' highlight reports although there should be eleven reports encompassing the period 14 January 2016 to 1 April 2016. The CCG Programme Manager has advised that these weekly reports were generally not provided, but matters were dealt with by the verbal presentations made by Coperforma. They were instead updated and presented monthly at the Programme Board meetings.

Mobilisation monitoring arrangements – Project Team

26.20 There was a Non-Urgent Patient Transport Service Clinical Commissioning Project Team (Project Team) with terms of reference dated October 2014. This Team was not specifically formed to monitor the effective implementation of the service as its primary role was service redesign and joint commissioning of PTS services. The only reference to the mobilisation stage was "to work with the Collaborative Delivery Team to support effective commissioning of PTS services and, ensuring clarity of roles and responsibilities between the two." The Project Team was accountable to the Programme Board via the membership of CCG's Programme Manager.

Mobilisation monitoring arrangements – Transition Meetings

26.21 Transition meetings took place between representatives from the seven CCGs, Coperforma, SECAmb and the PTB, with the first meeting being held on 26 November 2015 and the last meeting being a teleconference held on 30 March 2016. A total of 29 actions were raised at the teleconference on 30 March 2016 including actions such as:

- final opportunity to flag any potential issues/problems Coperforma anticipate for the first two weeks to the CCGs by 10am on 31 March 2016 so that the CCGs and Coperforma can put in place any mitigating actions in readiness for these
- obtaining confirmation that all the transport providers will have sufficient capacity to deliver assigned activity
- obtaining confirmation that a contingency plan is in place if the Patient Ready system is not available for any satellites/renal units etc. for 1 April.

26.22 The CCG has advised that it received assurance from Coperforma via the mobilisation process, and assurance meetings that Coperforma were ready for go live. There were a number of outstanding actions to resolve listed as part of the formal contractual process in terms of conditions precedent, and mobilisation plan, which required attention, but HWLH CCG considered the outstanding issues logged would not materially impact on effective operational delivery.

26.23 Coperforma was requested to flag any final potential issues/problems they anticipate for the first 2 weeks to the CCGs by 10am on 31 March 2016 so the CCGs and Coperforma can put in place any mitigating actions in readiness for these. We have been advised that no written response was received from Coperforma as the verbal feedback was that there were no concerns / issues without mitigation.

Assurance Meetings

26.24 At the 14 January 2016 Programme Board meeting the Chief Operating Officer of HWLH CCG and Chair of the Programme Board raised concerns about the the tight timescale for the delivery of the mobilisation plan and the need for ownership be everyone involved to avoid the failure to deliver against the key milestones. These concerns had arisen following meetings with both SECAmb and Coperforma. Furthermore, as concerns had been raised by the HWLH CCG Programme Manager with regards to how the mobilisation was progressing, a decision was taken (at a meeting held on 5 February 2016) to hold a formal meeting with Coperforma in order to obtain assurances that action would be taken to ensure progress in line with the planned mobilisation targets.

26.25 The assurance meeting was held on 15 February 2016, and this was attended by members of HWLH CCG and Coperforma. The purpose of the meeting was to assess the state of readiness of Coperforma to deliver the contract for 1 April 2016. The assessment involved a review of the contractual conditions precedent, the mobilisation plan, the Risk and Issues Log and other material requested by HWLH CCG (supplied by Coperforma and SECAmb). In total there were 28 contractual conditions precedent, 21 Actions from the CCGs, 16 Mobilisation Risks and one Programme Risk discussed.

26.26 A follow up meeting was subsequently held on 1 March to further assess progress. We have been advised by HWLH CCG that there were no concerns raised at this meeting and satisfactory written and verbal assurances were provided by Coperforma that they would be in a position to deliver the contract by 1 April 2016.

26.27 **Assessment:** The new PTS contract was not simply a case of a straightforward change of provider, but rather was the introduction of a new delivery model reflecting stakeholder and user feedback. There was a detailed and jointly agreed mobilisation transition plan, which the CCGs received written and / or verbal assurances, of delivery against milestones. The monitoring arrangements put in place by the Sussex CCGs during the mobilisation period did identify potential issues which indicated that

Coperforma may not be fully ready to deliver the service on 1 April 2016. However, Coperforma provided positive assurances that the mobilisation stage would be fully completed by 1 April 2016.

Area: The handover arrangements from South East Coast Ambulance Service to Coperforma that were agreed with HWLH CCG, and the extent to which compliance with these can be evidenced.

27. The following matters were noted from the work carried out during this review:

27.1 SECAmb had advised the CCGs in August 2015 that it would not be submitting a tender for the new PTS contract. Consequently the CCGs were aware at least seven months before 1 April 2016 that there would be a requirement for a transition and handover to a new provider.

27.2 It was noted that as part of a Mobilisation Plan dated November 2015 that the CCGs were to develop a protocol for managing the handover from SECAmb and PTB to Coperforma. We have been advised that the CCGs adopted a procedure of a series of transition meetings between the incumbent providers and Coperforma, supported by the Commissioners' HR, Contracting and Finance Teams to manage the transition, mobilisation and handover period.

27.3 In the Introductory Meeting between the CCGs and Coperforma held on 26 November 2015 the transfer of staff and TUPE matters were discussed, which concluded with the Chief Executive Officer of Coperforma stating that they would provide a written statement on how Coperforma was going to manage the transfer of staff. It was also noted that the CCGs stated their intention to discuss the potential for a phased transition.

27.4 SECAmb has advised that there was a disagreement by both parties on the release of staff for training. Coperforma wanted staff to be released for two weeks prior to the live date for training, whilst SECAmb advised it could only reasonably release staff for two days each.

27.5 In a meeting between the CCGs, Coperforma, SECAmb and the PTB on 3 December 2015 it was noted that the PTB were to work with SECAmb to provide a list of hospitals, clinics and departments (including community sites etc.) currently served by the PTS to Coperforma by 7 December 2015. It was also noted that SECAmb and the PTB were to provide Coperforma with a full set of activity data from November 2015, however, a post meeting update noted that it was postponed due to information governance issues until after the contract was signed. Although this issue was raised at subsequent Programme Board Meetings, there is no evidence to suggest that this issue was formally flagged as resulting in a risk of failing to meet the mobilisation timescales.

27.6 SECAmb provided a report on the timeline of events and actions taken by SECAmb regarding the transfer of the PTS. In a letter dated 7 December 2015 SECAmb stated that they did not want a phased transition and that a full handover of services was expected on 1 April 2016. Additionally, SECAmb requested a detailed contingency plan from the CCGs and Coperforma. On 15 December 2015 HWLH CCG's Accountable Officer gave assurance to SECAmb that Coperforma would be able to deliver the service from 1 April 2016.

27.7 **Assessment:** The handover arrangements required a balance between SECAmb being able to continue to deliver the PTS service up until the handover day and the requests from Coperforma for the transferring staff to be released for training. We

suggest that this is not unusual in a TUPE situation and Coperforma should have ensured there were appropriate mitigating actions in their mobilisation plan. The data requests from Coperforma were processed by the PTB and not SECAmb and consequently we do not consider the handover process from SECAmb to Coperforma to have resulted in insurmountable issues that could not have reasonably been expected to be addressed by Coperforma during this period.

Area: Sample check of cases of non-performance by Coperforma to assess whether these were as a result of failures in the mobilisation and handover arrangements, or whether there were other factors which gave rise to these failures

28. The following matters were noted:

28.1 Coperforma provided us with a high level summary complaints analysis report which identified that the principal cause of the service delivery issues during the early weeks of the contract was "peak volume overload".

28.2 Due to the ongoing service delivery issues which became evident during the review it was evident that a sample check of cases of non-performance in the first few days of the contract to identify reasons for failures in the mobilisation and handover arrangements had been superseded as the issues of non-performance were continuing. It was therefore agreed with HWLH CCG that we would instead provide an assessment as to the extent to which the non-performance extended beyond the mobilisation and handover phase into the first six weeks of the contract.

Complaints received by the CCGs

28.3 We requested copies of complaints logs for each of the Sussex CCGs for the period from 1 April – 30 April 2016. The individual CCGs advised us that any complaints received in relation to the PTS were either forwarded to HWLH CCG or directly to Coperforma. We recognise there may be a time lag between the actual time of a service failure and it being recorded by HWLH CCG, however the number of complaints recorded (Table 3 below) indicate more than just initial teething problems in the first week.

Table 3 - Number of complaints logged by HWLH CCG

	HWLH CCG
No of complaints from 1 April to 15 April	67
No of complaints from 16 April to 30 April	44
No of complaints from 1 May to 15 May	10
Total	121

Incidents logged by the Trusts

28.4 On 3 May 2016 we requested information from six of seven Trusts in Sussex serviced under this PTS contract. We visited each of these Trusts during May. We also visited Sussex Partnership NHS Foundation Trust, the mental health trust for Sussex, however they advised us that Coperforma are seldom used for transporting their patients. We therefore excluded Sussex Partnership from our analysis of the impact of the new PTS. It is noted that there were four days of national junior doctor strikes during April 2016, and consequently this may have impacted on the number daily journeys required.

28.5 The Trusts have advised that during this period they collectively raised 512 adverse incidents on the DATIX (electronic reporting form) relating to Patient Transport. It should be noted Trusts advised us that, where possible, they endeavoured to address matters locally with Coperforma's on-site staff. It was advised by many of the Trusts that during particularly busy times not all incidents were being formally logged given the time taken to do so. As a consequence, the true number of issues is likely to have been significantly higher than shown in Table 4 below.

Table 4 - Number of DATIX reports raised on Coperforma's PTS

	Surrey and Sussex Healthcare	Brighton and Sussex University Hospitals	East Sussex Healthcare	Queen Victoria Hospital	Western Sussex Hospitals	Sussex Community	Total
No logged from 1 April to 15 April	6	1	105	4	29	70	215
No logged from 16 April to 30 April	17	11	100	14	22	32	196
No logged from 1 May to 15 May	6	17	35	3	23	17	101
Total	29	29	240	21	74	119	512

Note: It is possible that DATIX entries include some duplicates

Mitigating actions taken by the Trusts

28.6 When it became evident that patients were not being collected from hospitals each of the Trusts increased their existing local arrangements to provide additional transport. These local arrangements will have reduced the number of potential DATIX incidents which would otherwise have had arisen. These arrangements are summarised in Table 5 below.

Table 5 - Analysis of additional transport arrangements put in place by the Trusts during April 2016

Trust	Local transport arrangements
Surrey and Sussex Healthcare	Use of 47 taxi journeys and 200 discharge journeys using a directly contracted patient transport company.
Brighton and Sussex University Hospitals	Doubled the use of their Private Ambulance facility. Significant use of taxis for patients. This could not be quantified at the time of the visit.
East Sussex Healthcare	For April - 203 journeys undertaken by private vehicles (including 23 by relatives as transport not available).
Queen Victoria Hospital	Use of a directly contracted patient transport company whenever Coperforma failed.
Western Sussex Hospitals	4 dedicated vehicles provided by Coperforma.

Trust	Local transport arrangements
Sussex Community	Services book taxis currently at their expense (although it is often the case that a taxi is not an appropriate form of transport), or advise patients to book a taxi at their own expense.

Assessment of service delivery as at 13th May 2016

28.7 Table 6 below represents each Trust's evaluation of the delivery service provided by Coperforma as at 13th May 2016 – 43 days after the contract commencement date. An Assessment Scoring Criteria (Table 6 below) was provided to the staff who were the contact points we were provided with for the Trusts and who were directly involved in the PTS at each Trust to provide a means of evaluating their assessment. These assessments are not formal evaluations by the Trusts, and were obtained by TIAA solely for the purposes of providing us with an indication from the 'front-line' as to whether service delivery issues solely related to the immediate contract commencement phase, or appeared to be longer term.

Table 6 - Trusts' evaluation on Coperforma's Delivery Service

Assessment	Surrey & Sussex Healthcare	Brighton and Sussex University Hospitals	East Sussex Healthcare	Queen Victoria Hospital	Western Sussex Hospitals	Sussex Community
Daytime Coperforma's delivery service as at 13th May is fit for purpose, with delays and failures to deliver or collect patients now being the exception between 09:00 and 17:00 Monday to Friday.	1	2	1	1	1	1
Nightime Coperforma's delivery service as at 13th May is fit for purpose, with delays and failures to deliver or collect patients now being the exception between 17:00 and 09:00 Monday to Friday.	1	1	1	1	2	1
Weekend Coperforma's delivery service as at 13th May is fit for purpose, with delays and failures to deliver or collect patients now being the exception on Saturdays and Sundays.	1	2	1	Not Applicable	2	Not Applicable

Table 7 - Assessment Scoring Criteria

Score	Assessment
1	Service cannot be relied upon as are still a large number of failures every day to deliver or collect patients at the required times and there is no real sign of the causes of the failures being addressed in the foreseeable future.
2	Service cannot be relied upon as are still a number of failures every day to deliver or collect patients at the required times, but it has improved over the performance in April.
3	Service can now be relied upon, though there are still occasional failures to deliver or collect patients at the required times and these have to be addressed using local transport and similar.
4	Service can now be relied upon, though there are still occasional failures to deliver or collect patients at the required times but such failures are now exceptions and are quickly addressed.

28.8 We were also advised by a number of the Trusts that there were occasions when patients due for discharge had to be kept in overnight when transport did not arrive. We have not been able to quantify this.

Reasonableness of the length of the mobilisation period

28.9 We have looked at the mobilisation period for a sample of other recent PTS contracts in other counties (Table 8 below). This indicates that the mobilisation period of 4 months for the PTS contract in Sussex was in line with the sample. It is not clear, however, whether the extent of changes in the specification design/scope and delivery model at others in the sample were as significant as those involved with the Sussex contract. Likewise the mobilisation period at Sussex was effectively reduced to only 2 months with respect to certain aspects not progressing until the contract was fully signed at the end of January.

Table 8 - Length of mobilisation stage at a sample of other PTS contracts

County	Mobilisation period
Bristol	3 months
Devon	3 months
Essex	3 months
East Midlands	3 months
Sussex	*4 months*
Lincolnshire	5 months
Somerset	5 months
Kent	6 months
Norfolk	6 months
Surrey	6 months

28.10 **Assessment:** From the information which has been provided to us it is clear that issues of non-performance were not limited to the initial start-up of the contract. It is clear that Trusts receiving patients have been assisting in mitigating some of the non-performance issues beyond the initial start of the contract, and that without this assistance the actual position during April 2016 would have been significantly worse. The fact that there were new complaints being received by the CGGs, and formal

incidents were being recorded by all of the Trusts during the third and fourth week of the contract indicates there may be underlying issues, rather than mobilisation-related issues that have yet to be fully addressed.

Area: Establish the reasons for the failure of the service delivery on commencement of the new contract by Coperforma, and whether these could have been reasonably anticipated prior to the contract commencement date.

29. The following matters were noted:

29.1 On 5 April 2016 Coperforma advised that: "Coperforma accepts that the level of service it has been able to provide over the first few days of its Sussex provision is unacceptable. Whilst Coperforma takes full responsibility for the situation, a number of factors outside of our control at the takeover point contributed to a 'perfect storm' that have mitigated against as successful a start to the service as had been planned." The statement also provided details of reasons for the problems as being:

- 'Hundreds' of new journey bookings were 'unnecessarily withheld' until 11.15pm on Thursday night and the reasons for this are being investigated.
- Patients being told that 40 to 50 per cent of renal patients would no longer be receiving NHS Hospital transport caused huge anxiety and understandably resulted in thousands of calls from anxious patients.
- Patients being advised in the days before handover to call back after 1 April 2016, to make bookings and re-confirm their existing future bookings, has again caused unnecessary stress for patients and caused unnecessary call volume.
- The 'late timing of the data' presented 'huge challenges' to its transfer into the booking system.

29.2 Coperforma also advised that "We have added 18 additional staff into our Demand Centres and are working hard to extend the on-line access to patients and clinical staff to ensure that going forward we deliver the service that all patients and NHS clinical staff expect and deserve."

29.3 On the same day HWLH CCG, on behalf of the Sussex CCGs, announced that the problems had been due to "a number of complex issues, including problems with data transfer and patient booking information". Apologising to all users of the service, they advised they were working with Coperforma "to ensure the service meets the needs of our population as quickly as possible".

Live Data Transfer

29.4 We have considered the extent to which the matters listed below, which were raised as problems by Coperforma, could have reasonably been anticipated:

'Hundreds' of new journey bookings were 'unnecessarily withheld' until 11.15pm on Thursday night and the reasons for this are being investigated.

The 'late timing of the data' presented 'huge challenges' to its transfer into the booking system.

29.5 One of the conditions precedent set out in the contract outline was that a data transfer agreement needed to be in place between Coperforma and the incumbent Provider prior to the transfer of any patient data.

29.6 We have been advised that a Data Sharing Agreement was signed at the end of February or early March 2016. This Agreement allowed for post March 2016 activity data to be passed to Coperforma. Prior to this transfer taking place HWLH CCG undertook an Information Governance compliance exercise, and wrote to all patients requesting permission to send all their details for future bookings to Coperforma. These patients had up until the 22 March 2016 to respond and to state if they did not wish to have their details transferred. We understand the data transfer took place in February and on 22 March 2016.

29.7 A consequence of this late data sharing approval exercise meant that live data for the period from 1 April 2016 was only provided five clear working days before the start date of the service delivery by Coperforma. We have been advised the reason for this information governance exercise being carried out so close to the transfer date was that there was a delay at the Programme Board in agreeing the content of the letters as the feedback from the CCGs Patient Forum was that the initial wording was not suitable.

29.8 We have been unable to independently verify the details or the actual timing of these data transfers. However, we have been advised there was a third data transfer on the 30 March 2016 of all planned journeys for April - July 2016. We also understand there was a fourth data transfer on the 31 March 2016 of any additional bookings made since the third data transfer and a final fifth transfer immediately prior to the PTB system being switched off for the final time.

29.9 We have been unable to independently verify the details or the actual timing of the data transfer as the PTB is no longer in existence and we have not been provided with evidence of the dataset transfers that were provided to Coperforma during the implementation phase.

29.10 Issues regarding the completeness and accuracy of some of the data transferred from the PTB to Coperforma are subject to a separate investigation. We understand the number of records concerned is small in relation to the overall total number of records.

29.11 There was a clear need for this ongoing transfer of live data in the lead up to the contract start date as there was no parallel system running, and the PTB was continuing to take bookings for after 1 April 2016. It would not therefore have been possible to transfer the data for April bookings at a much earlier stage.

Increase in the number of calls received

29.12 We have considered the extent to which the matters listed below, which were raised as problems by Coperforma, could have reasonably been anticipated:

> *Patients being told that 40 to 50 per cent of renal patients would no longer be receiving NHS Hospital transport caused huge anxiety and understandably resulted in thousands of calls from anxious patients.*
>
> *Patients being advised in the days before handover to call back after 1 April 2016, to make bookings and re-confirm their existing future bookings, has again caused unnecessary stress for patients and caused unnecessary call volume.*

29.13 **Number of calls:** A review of the call volumes provided by Coperforma for the first two weeks of April 2016 identified the following:

- Number of calls received on Friday 1 April 2016 was significantly higher (4,484 calls) than the average number of calls per day received for the first two weeks of April (2,127 calls).
- It is noted a similar high level of calls (4,516 calls) were received on Monday 4 April 2016.
- During the first week of operation there were 17,936 calls compared to 11,838 calls during the second week of operation.
- The records provided by Coperforma show that for the first two weeks of operation, out of the 29,774 calls received, 18,402 were not answered (38% answered / 62% unanswered).

29.14 We have been unable to establish what percentage of the calls to Coperforma were from renal patients who were concerned about whether they were still eligible for patient transport.

29.15 There are a number of factors which may have affected the volume of calls on both Friday 1 April and Monday 4 April 2016 and led to the higher than average number, compared to that for later in the month. We have been unable to assess these factors either separately or collectively:

- callers ringing back because they could not get through the first time
- calls from Trusts because they were unable to book online
- calls from sub-contractors' drivers because they were not yet fully experienced in using the mobile worker system

29.16 We have been advised that there were no formal instructions or guidance issued directly by the CCGs requesting that patients would need to call the new provider post 1 April 2016.

29.17 The PTB is no longer in existence so we have been unable to establish whether any formal instructions or guidance were issued by the PTB that, due to the change in provider, patients would need to call the new provider post 1 April 2016.

29.18 We have been advised that SECAmb did not provide any formal guidance to their drivers on how to respond to queries by their patients regarding the new contract delivery or the revised patient assessment process. It is not possible to establish whether any of their drivers may have conversed with patients which could have resulted in the increase in calls.

29.19 **Availability of Call Answering Staff:** As with any TUPE transfer the individual members of staff have until the actual date of transfer to decide whether they will actually transfer. We understand in the months leading up to the transfer there had been a moratorium on employing new staff at the PTB, and as a consequence the potential number of staff who were eligible to transfer to Coperforma was significantly less than that which was required to deliver the services being provided by the PTB. Coperforma has advised us they were satisfied they had the right number of on-line booking system and telephone responders in place for 1 April 2016, but that the actual number of calls received was far in excess of that which was anticipated and the situation was further compounded by the duration of the individual calls being longer than anticipated as Coperforma's staff wanted to allay individual callers concerns. We have been advised by Coperforma that as a consequence of these reasons there was an immediate lack of additional trained capacity to absorb this level of calls on subsequent days.

29.20 **Ability of the Trusts to make on-line bookings:** The on-line booking of transport by staff at Trusts was designed to reduce the number of calls made. Records provided by Coperforma indicate that the roll out of passwords for the Trusts' staff was not carried out in a timely manner, see Table 9 below. We have not been able to establish the extent that any issues relating to obtaining access to the individual Trust's ICT system impacted upon the small number of access rights which were in place at 1 April 2016. We consider this phase of the implementation could have been carried out during the months leading up to April 2016.

Table 9 - Number of password access rights provided to Trusts

Date	Number of access rights in place
1 April 2016	88
15 April 2016	363
30 April 2016	568
15 May 2016	1,468

29.21 A review of the access rights data highlighted the following position on 1 April 2016:

- Surrey and Sussex Healthcare NHS Trust had 70 users leaving only 18 users with access across the remaining Trusts.
- There were no users with access rights at West Sussex Hospitals NHS Foundation Trust or Queen Victoria Hospitals NHS Foundation Trust.
- There were only nine users with access rights at Brighton and Sussex University Hospitals NHS Trust

Possible Contributory Factor - Data Transfer for demand modelling

29.22 An Information Sharing Agreement was signed by Coperforma and the Head of the PTB on the 23 December 2015. Under the agreement all PTS patient and journey details for the year from 1 January to 23 December 2015 inclusive were provided by the PTB to Coperforma. We have been advised this data was to be used by Coperforma to stress test their PCS system, and also to provide modelling of demand patterns.

Data transfer

29.23 Coperforma initially advised us that they did not receive a full year's worth of data as requested in the data sharing agreement. Subsequently, Coperforma advised us that twelve months data was provided by the PTB on 24 December 2015, but that it contained such a high level of discrepancies that by 13 January 2016, after a number of attempts to resolve discrepancies Coperforma determined it could no longer wait for correct dataset and consequently created an estimate of the likely workload.

29.24 Coperforma has also advised that on 30 December 2015 they received via the PTB a sample month of SECAmb data.

29.25 HWLH CCG did not have right of access to this data as it included patient identifiable data. Consequently staff from HWLH CCG were not in a position to confirm the accuracy and completeness of the data transferred.

29.26 At the Programme Board meeting on 14 January 2016 Coperforma noted that circa 20% of journeys were missing, but no suggested remedial action was proposed. It is noted that Coperfoma's response suggest it had the necessary data to carry demand

modelling and the comment did not indicate that Coperforma was awaiting a new transfer of the 12 month data for demand modelling purposes.

29.27 At the weekly Programme Board Coperforma's Highlight Report for 26 February 2016 includes the risk log, but there is no mention of issues in relation to the data provided for demand modelling purposes. HWLH CCG has advised us that Coperforma did not ask the CCG to provide any additional data for 2015 to supplement the PTB's data transfer or any request to receive a data transfer directly from SECAmb.

29.28 Coperforma has advised us that their Programme team considered the lack of 12 months clean data was considered to be an acceptable risk as no material progress had been made on resolving it since raising it in the Bid and subsequent project meetings. Coperforma further advised that by 26 February 2016 the time had passed to do anything about it due to the lead times involved with having vehicles and crews available.

29.29 Coperforma has advised that in their opinion the data required should have been provided from SECAmb's system as this data would have more easily supported the modelling of the six Trusts and the long distance journeys between them, plus the to and from other care providers within Sussex and journeys in and out of Sussex to be modelled discretely to capture the nuances across the county, within each Trust and variations on service scope.

29.30 Coperforma has advised us that the incompleteness of the transfer of patient and journey details data for the year from 1 January to 23 December 2015 prevented seasonality analysis and workload peaks from being modelled. Irrespective of whether there was a full or partial data transfer Coperforma did not formally raise with HWLH CCG that this was material or adversely impacted on their ability to model capacity requirements across Sussex. Coperforma has advised that this was because their project team was satisfied that their contingency cover arrangements would be adequate to accommodate any peaks in demand and capacity.

Advance Modelling of likely demand patterns

29.31 At a Project Team meeting on 5 January 2016 Coperforma advised the CCGs that their traffic-related contingency planning system included expected loading times, transit times between the clinic/home and vehicle, and travel times (based on average traffic levels) when scheduling collection times. Coperforma has provided us with:

- A Powerpoint presentation which we understand was prepared using the data provided at the tender submission stage. We were unable to establish from this Powerpoint how the geography and road infrastructure across Sussex were sufficiently factored into their modelling so as to give confidence that they would operate in accordance with the Key Performance Indicators regarding service delivery.
- An Excel spreadsheet entitled 'Sussex Transport costing' which provides the assumptions made regarding average journey times per type of vehicle. This spreadsheet would appear to have been prepared for financial, rather than operational planning purposes. We note that this spreadsheet does not appear to factor in the resilience required to service six geographically dispersed Trusts. We have not tested the reasonableness of the assumptions made within the spreadsheet.

29.32 We have been advised by Coperforma that the 'Sussex Transport costing' is part of a more complex model used from the initial scoping for Bid/No Bid decisions through to Mobilisation planning.

Other possible Contributory Factors

29.33 It is clear from the ongoing issues being experienced during the second half of April and throughout May 2016 that data transfer problems and a high level of phone calls were not in themselves the principal underlying reasons for the initial failure to meet the contracted Key Performance Indicators regarding service delivery. This is on the basis that if these were the only issues we would have expected them to have been quickly resolved, and our findings indicate that service levels are still well below target six weeks after the commencement of the contract.

29.34 We have therefore considered other main elements of the service delivery which appear to have contributed most to this situation. It is noted that these were not cited by Coperforma in their statement on 5 April 2016 as reasons for the problems experienced during the first few days of the delivery of the PTS.

29.35 **Field trials of system prior to 1 April 2016:** Coperforma has not advised us of the timing or extent of their field tests of the new processes in advance of 1 April 2016. We cannot therefore comment upon whether the new service delivery processes were effectively tested at the contract start date.

29.36 **Parallel running during mobilisation period:** It is clear that the intention set out in Coperforma's Mobilisation Plan of effectively running parallel to the PTB in the three month period prior to April 2016 was not achieved. It was highlighted in Coperforma's tender submission that one of the risks associated with the transition was that there may be errors in the data provided by the current provider. To mitigate this they would therefore provide 100% contingency capacity for transport if needed and an overlay team for 100% additional capacity in the demand centres. We have seen no evidence that Coperforma raised the absence of a parallel run as preventing them being ready to operate on 1 April 2016.

29.37 **Commissioning of hub offices:** In the Mobilisation Plan provided by Coperforma on 4 December 2015 Coperforma outlined that they would be obtaining incremental weekly transfers of all patient bookings from SECAmb ready for the setup of 'the Hub' to enable Coperforma to become operational in January 2016. The planned start date for this process was 14 December 2015 with 'the Hub' being set up on 11 January 2016. Coperforma's initial plan was to use the Hub from 11 January 2016 to manage bookings post 1 April 2016. However, there were delays in signing the lease for the Hub, which did not take place until 29 February 2016. We have been advised by HWLH CCG that the reasons for the delay in setting up the Durrington office were associated with the lease, and kitting out the space to make it compliant with Information Governance requirements. Assurances were given by Coperforma that they would set up the demand centre in a nearby hotel if it was not ready. For the Eastbourne office, this was identified immediately because Coperforma was in conversations with SECAmb about potentially using their office space. When this option failed to materialise Coperforma identified and secured a base in Eastbourne which was kitted out in time. We have seen no evidence that Coperforma raised the delays in commissioning these hub offices as preventing them from being ready to operate on 1 April 2016.

29.38 **Availability of drivers:** The vehicles and their crews are being provided by a number of sub-contractors, over whom Coperforma does not have any direct management control. Coperforma provided assurances that it would have a 100% excess of drivers available on 1 April 2016 in advance of their final assurance meeting with the held by HWLH CCG. We have been advised by Coperforma that there were 296 drivers available on 1 April 2016, though it is not clear how many vehicles were available and whether collectively the number of drivers and vehicles equated to a 100% effective excess cover.

29.39 **Drivers' access to Mobile Work App via PDA:** Drivers are provided with a PDA through which transport bookings are received, and they can input their current status (e.g. available, picked up patient, delivered patient, etc.). Coperforma has provided us with the following information (Table 10 below) regarding availability of this PDA which shows that many drivers did not have a PDA at the start of the contract. We have been advised by Coperforma that drivers without PDAs were contactable by mobile telephones.

Table 10 - Number of driver PDAs issued

Date	Number of driver PDAs provided
1 April 2016	110
28 April 2016	190

29.40 Coperforma provided us with the following information regarding journeys carried out by their different sub-contractors (Table 11 below). It should be noted that we have been advised by Coperforma that PTS24/7 drivers do have PDAs but their journeys are booked via the sub-contractor's booking system which does not directly interface with the PCS system.

Table 11 - Number of Journeys carried out by the subcontractors

Sub-contractor	1 April 2016	28 April 2016
ELITE	4	21
FAST	0	11
MEDICAR	15	42
PTS24/7	855	517
Southern Ambulance	25	33
Thames Ambulance	17	122
VM Langfords	67	350
Totals	983	1,096

29.41 **Previous experience of mobilising for a similar size PTS Contract:** We have been informed by Coperforma that they their "PCS system & Mobile Workers application have been running for the last four years in Hampshire and London" and that they cover all of Hampshire excluding Southampton and therefore they already covered a geographical area compatible with Sussex. These contracts are each individually significantly smaller in terms of financial value than the Sussex PTS. We have also

been advised that they have experience of a larger TUPE transfer than occurred in Sussex. We have established that this previous experience relates to contracts with individual Trusts, rather than a pan-county contract with a number of Trusts. Coperforma has advised us that in hindsight the Sussex PTS contract should have been mobilised as though it was six different sub-contracts. This indicates that the Sussex mobilisation was significantly larger in terms of scale and complexity than had been previously experienced by Coperforma.

29.42 **Service Delivery officers:** We acknowledge the significant positive contribution made by the Coperforma liaison staff based at the Trusts. This is reinforced by the Trusts indicating that the service delivery declined markedly when these staff have completed their working day.

29.43 **Assessment:** The processes put in place by Coperforma were markedly different to those operated previously by SECAmb and the PTB. We have examined the initial reasons stated by Coperforma as being the two principal causes of the poor performance, (high volume of calls and errors in the live data transferred), and we suggest that these were the only factors they should have been capable of being addressed in a number of days rather than weeks. The fact that significant service delivery issues were still being experienced six weeks after the contract start date therefore suggest that there were other reasons for the poor service delivery. Our findings indicate that the poor service delivery was a combination of a number of factors and that individually each of these factors would have been unlikely to cause such poor performance. It is therefore the combination of these factors which created the situation whereby on 1 April 2016 Coperforma had an insufficiently tested Sussex-wide infrastructure which was expected to be able to seamlessly bed in after the contract start date without any adverse on service delivery. Any concerns Coperforma may have had immediately prior to 1 April 2016 with these factors either individually or collectively on their readiness to deliver the PTS service were not raised with HWLH CCG. The combination of key factors which indicate the arrangements had not been bedded in are listed below in no priority order:

- **Data transfer of demand modelling:** The migration from a primarily paper-based system to a technology-based system required significant data analysis to determine future demand and capacity patterns. The data transfer for this was direct from the PTB to Coperforma, as the CCG was not authorised to have access to the data. Due to issues with the quality of data Coperforma was unable to use the data for level of detailed demand modelling they have anticipated. However, Coperforma did not formally raise this as a significant issue with the CCGs that this was a potential no-go for going live. The reasons for this was that Coperforma had anticipated their contingency cover would have accommodated peaks in demand and capacity.
- **Advance Modelling of likely demand patterns:** It is clear from the information we have been provided with that the opportunity to fully utilise historic data for advance modelling cannot have been utilised effectively to identify the potentially competing demands of the geographically dispersed Trusts.
- **Field testing of system prior to 1 April 2016:** We would expect there to have been comprehensive testing by Coperforma and its sub-contractors prior to 1 April 2016. We suggest such testing could have highlighted some operational issues which would have enabled an interim solution to be put in place on 1 April 2016 to mitigate their impact. Coperforma has verbally advised us that field testing was carried out, but we have not been provided with any supporting evidence on the

nature and extent of their testing of the system across Sussex and with multiple Trust locations. We are therefore unable to comment on the adequacy of any field testing of their system.

- **Parallel running during mobilisation period:** It is clear that the intention set out in Coperforma's Mobilisation Plan of effectively running parallel to the PTB in the three month period prior to April 2016 was not achieved.
- **Commissioning of hub offices:** The hub offices at Durrington and Eastbourne were not ready for use until very shortly before the start of April, which was several months behind the schedule set out in Coperforma's mobilisation plan.
- **Drivers' access to Mobile Work App via PDA:** There was a 72% increase in the number of PDAs being used between the start and end of April which suggests there were insufficient in place at the contract start date.
- **Data Transfer of journeys required post 1 April 2016:** As this matter is subject to a separate investigation we have only been provided with limited data by Coperforma and we are therefore unable to establish the extent of these errors, the impact of this on service delivery in April 2016, or indeed how swiftly these errors were identified and removed.
- **Number of calls:** The records indicate there was a significant increase in the number of calls made to Coperforma during the first week of the contract. We suggest it would not have been unreasonable to expect an increase in calls at the start of a new contract and that appropriate resilience arrangements would have been made. However, the number of actual calls was higher than we suggest could have been reasonably expected and this increase also was exacerbated by Coperforma's staff spending longer than planned in reassuring callers as well as the knock-on impact of the failures in other areas of the service delivery.
- **Roll out of the online booking facility:** The opportunity to train up an adequate number of staff at the Trusts to make on-line bookings which would have assisted in reducing the number of calls was missed as evidenced by there being only 88 log-in rights on 1 April 2016 which had increased to 1,468 by the middle of May 2016.
- **Previous experience of mobilising for a similar size Patient Transport Service Contract:** Previous experience of commissioning a similar Patient Transport Service contract in terms of scale and complexity should have provided for a tried and tested mobilisation process and timetable which would then have identified and assessed in a timely manner the cumulative effect of slippages on being ready for the 1 April 2016. Prior to being awarded the Sussex PTS contract Coperforma's experience of delivering patient transport was through a number of smaller value contracts.

Area: The appropriateness and timeliness of the actions taken by HWLH CCG and Coperforma

30. The following matters were noted:

30.1 On 5 April 2016 Coperforma advised on its website that "currently our phone lines are extra busy due to calls coming in from patients booking appointments weeks ahead, stopping calls getting through to us from those requiring urgent transport to attend daily dialysis or radiotherapy clinics. Our system is designed to work on this shorter booking timeframe, with Coperforma calling 24 hours ahead of the booking to reconfirm each journey." "If patients and clinical staff could help in this way, we will be able to clear the

current backlog much faster thus helping to ensure no-one misses their regular treatments." On the same day Coperforma also advised that it had "added 18 additional staff into our Demand Centres and are working hard to extend the on-line access to patients and clinical staff to ensure that going forward we deliver the service that all patients and NHS clinical staff expect and deserve." It is noted that at this time there was no indication of the likely timespan for the remedial actions to be effective.

30.2 During April 2016 HWLH CCG took the following actions to expedite an improvement in service delivery by Coperforma:

- Weekly calls with all Trusts, Copperforma and CCGs
- Remedial Action Plan (RAP)
- Weekly Highlights Reports from Coperforma to report on progress against the RAP

30.3 As a means of attempting to address these issues, a Remedial Action Plan (RAP) has been developed jointly between HWLH CCG and Coperforma. (This is the first step of the formal contract monitoring process CCGs must follow under the terms of the standard NHS contract in response to a breach of contract by a service or provider). There are a total of 14 Improvement Objectives set out in the RAP, supported by a total of 35 specific actions.

30.4 HWLH CCG and Coperforma are also holding weekly Remedial Action Plan Review (RAPR) meetings as the forum for formally recording progress and developments under the agreed RAP. The RAP sets out:

- Actions required and which party is responsible for completion of each action
- Improvements in outcomes and other key indicators required
- The date by which an action or improvement is to be achieved
- Consequences for any party failing to achieve/maintain the improvement required

30.5 A Weekly Highlight Report is now also being produced, setting out performance against the improvement plan targets. Although it was recognised that issues existed within the first few days of the contract, the RAP was formally prepared in early May and the first RAPR meeting was held on 13 May 2016, six weeks after the contract start date. We have not reviewed the effectiveness of the RAP arrangements.

30.6 As a result of the continued poor performance a formal complaints process was set up by the CCGs in April 2016 with a designated Complaints Lead available for each CCG to record and respond to all complainants. It was also noted that Coperforma established a complaints procedure, whereby Coperforma would provide an initial response within 15 working days of receipt of the complaint and close the complaint within 25 working days. We have not reviewed whether these deadlines have and are being met.

30.7 At 13 May 2016, it was reported that, whilst there are some areas of improvement, the PTS continues to operate below standard. This is supported by feedback obtained by TIAA in mid-May from Trusts' representatives.

30.8 On 25 May 2016 the CCGs issued a collective statement that the "CCGs in Sussex are working with local hospitals and Coperforma to support the implementation of immediate actions to address the data, Information Technology, vehicle and workforce issues we know have impacted on the service to date. Coperforma's performance is also being monitored by HWLH CCG, on behalf of all the Sussex CCGs, against agreed

improvement targets for phone call waiting times, outward journeys from a patient's home and pick-up times after outpatient appointments or a hospital stay".

Recommended remedial actions

30.9 The current focus of the CCGs and Coperforma is on ensuring that service delivery becomes contract and KPI compliant at the earliest opportunity. In addition to the actions being agreed and monitored as part of the RAP we suggest there are a number of additional remedial actions which should also be carried out concurrently.

30.10 **Assurance that there will be a consistent and full achievement of the KPIs:** We are unable to warrant that the remedial actions being taken by Coperforma will fully address the service delivery issues by July 2016. There is a need for the CCGs, Trusts and patients to be reassured that remedial actions being taken are will achieve a full rectification of the service delivery such that the KPIs are consistently and sustainably met by Coperforma at the earliest opportunity. We recommend that this can best be achieved by the consideration of the appointment of an independent patient transport service specialist to support the CCG in overseeing Coperforma's remedial action plan and service resilience until PTS is operating as 'Business as Usual'.

Recommendation: 1	Priority: 1
An independent patient transport service specialist be considered to support the CCG to oversee Coperforma's remedial action plan and service resilience until the PTS is operating as 'Business as Usual'.	

30.11 **Recovery of Trusts' costs associated with the failures to perform the contract in accordance with the KPIs:** The contract specification provides that sanctions will be applied in relation to under-achievement of KPIs up to a maximum of 2% of the contract value, apportioned over a twelve month period of under-achievement. The contract specification would not appear to have foreseen a situation in terms of failures in service delivery of the extent which occurred during the first six weeks of the contract. It is clear that Trusts have suffered financial costs associated with the non-performance of the service, both in terms of proving additional transport, and also overtime and rescheduling of cancelled appointments. Each Trust should be requested to prepare a schedule of their additional costs incurred. These schedules, less any of these costs which have already been submitted to Coperforma, should be submitted to HWLH CCG. HWLH CCG should then take appropriate legal advice regarding their ability to recover these costs, before deducting the direct costs incurred by Trusts (which have not already been passed on to Coperforma) from the next stage payment to Coperforma.

Recommendation: 2	Priority: 1
Each of the Trusts in Sussex be requested to identify additional costs they have incurred and submit theses to HWLH CCG for contractual discussion with Coperforma.	

30.12 **Recovery of the CCGs costs associated with the failures to perform the contract in accordance with the KPIs:** In addition to the Trusts, HWLH CCG has also incurred costs arising from the failures of the service delivery by Coperforma which exceed that which could have been reasonably expected for the ongoing supervision of the

contract. Legal advice should be taken regarding whether such costs can be recovered from Coperforma.

Recommendation: 3	Priority: 2
Consideration should be given to establishing whether there is legal entitlement to recover CCGs additional costs arising from Coperforma's failures of contract performance.	

30.13 **Failure to carry out all required journeys:** It has not been possible to quantify the number of patients who made their own alternative arrangements to attend hospital appointments, or for their subsequent return journey from hospital in the first six weeks of the contract. We have also been unable to establish how many patients did not attend hospital appointments as transport was not provided. We suggest that consideration is given to waiting until a typical month in terms of patient journeys can be accurately calculated, and with this information the shortfall in the number of journeys delivered by Coperforma in April and May 2016 can be assessed. Legal advice should be taken regarding whether restitution can be made from Coperforma for the shortfall in actual journeys performed against the number that were actually required.

Recommendation: 4	Priority: 1
Consideration should be given to establishing whether there are grounds for financial recovery due to the contract failure in terms of number of journeys not properly delivered during April and May 2016.	

30.14 **Assessment:** Poor performance and service issues impacting on patient experience and the delivery of the PTS were identified very quickly by both Coperforma and HWLH CCG. Once it became evident that the problems were not going to be rectified within a short number of days Sussex CCGs put in place arrangements designed to constructively assist Coperforma to improve its service delivery. HWLH CCG remained focussed that any remedial actions taken by the CCGs must not inadvertently further jeopardise patients being collected and delivered on time.

Area: Any lessons learned which could be incorporated into other future major contracts let by HWLH CCG

31. The following matters were noted during this review:

Programme Board

31.1 The terms of reference for the Programme Board were amended to reflect the addition of Coperforma representatives in January and formally ratified at the Programme Board meeting in March, three weeks prior to the actual contract commencement date. Whilst we do not consider that this had any significant bearing on the overall monitoring arrangements it would be good governance to have terms of reference agreed at the first meeting.

Recommendation: 5	Priority: 2
The terms of reference for any mobilisation Board or similar be agreed at the first meeting.	

31.2 Where contracts are being implemented on behalf of a number of CCGs then regular attendance levels at the meetings of the Programme Board for the contract should be required.

Recommendation: 6	Priority: 2
Failure to attend key mobilisation meetings should be noted and escalated appropriately (internally and externally).	

Prompt signing of contracts when carried out jointly with a number of other CCGS

31.3 The contract for the PTS was awarded by the seven CCGs and it is noted that it took a month to get the contract signed by all of the CCGs. We suggest that for jointly procured contracts it is confirmed by legal advisors that the documentation can make it explicitly clear that the signature of the appropriate person from the lead CCG is legally binding and signatures from the other participating CCGs are not required before contract mobilisation can commence.

Recommendation: 7	Priority: 2
Legal advice be taken to confirm that the tender and contract documentation can make it explicitly clear that the signature of the appropriate person from the lead CCG is legally binding and signatures from the other participating CCGs are not required before contract mobilisation can commence.	

Absence of a 'Plan B'

31.4 The Tender Ratification Report (dated 23 October 2015) raised this as one of the main risks associated with awarding this contract:

> There is a risk that procurement sign off will not be achievable if one or more of the CCGs decided it is not satisfied with the recommendation of the preferred bidder status following the procurement process. If this was to occur, the procurement process would be halted; which could result in being unable to award the contract and therefore have a new service in place from 1 April 2016. If this was to occur, the CCGs would have to consider and put forward a contingency plan to ensure that provision was not affected and patients received continuity of service. The options for this would include re-negotiating a further extension with the incumbent provider or an interim arrangement with the PTB's framework providers.

31.5 There was no evidence to show that this risk had been formally considered and/or appropriate contingency plans put forward at this stage, as a decision was taken to award the contract to the preferred bidder.

31.6 Reference is also made to the need for the CCGs to develop a contingency plan in the Risk and Issues Log dated 24 November 2015, which was owned by the Project Team. Additionally, it is outlined in the tender documents provided by Coperforma that they had included a contingency plan for the transition phase of the contact in case there were any issues with the data. We have been advised by HWLH CCG that a contingency plan was never actually prepared, as HWLH CCG received assurance of Coperforma's readiness to mobilise and deliver the service from day one.

31.7 SECAmb outlined in a letter to HWLH CCG on 18 February 2016 that they were concerned that Coperforma may not be able to deliver the service from 1 April 2016, and that SECAmb was willing to work with HWLH CCG to mitigate any risks.

31.8 We have been advised that representatives from HWLH CCG met with SECAmb to discuss the content of the letter. At this time, the CCGs were completing a two-stage assurance meeting process with Coperforma, and were focused on gaining assurance of delivery of outstanding actions. We understand HWLH CCG offered to hold an additional meeting with SECAmb after the additional assurance meeting, but this was not required due to the assurance received at the meeting on 1 March 2016 and was therefore postponed.

31.9 The HWLH CCG Programme Manager has advised there was no formal consideration given to a 'Plan B' as it was not considered to be required and would be difficult, given that the PTB was being disbanded and that SECAmb could not deliver both the booking and scheduling activities and that all booking and dispatch staff were being TUPE transferred from the PTB and SECAmb to Coperforma on 1 April 2016.

31.10 In an email from the HWLH CCG Programme Manager dated 30 March 2016, which was sent to Coperforma, it is noted that the CCGs were requesting that Coperforma confirm their contingency plans if the Patient Ready System is unavailable. We have been advised by HWLH CCG that Coperforma did not provide a contingency plan in response to this request, nor did they provide a list of any potential risks and issues that faced the service in the first two weeks delivery, as requested from Coperforma's Programme Manager on 30 March. It was further advised that Coperforma gave verbal assurance that all potential risks and issues had been addressed by mitigating actions, and they had no concerns about the delivery of the service from 1 April 2016.

Recommendation: 8	**Priority: 1**
Contingency arrangements be built into the planning process for major contracts where significant service changes are anticipated.	

Failure to consider a phased implementation

31.11 The changes in service delivery being implemented under the new contract were significant, and were compounded by the implementation of new eligibility criteria for renal patients. We suggest that a phased implementation could have been considered. Whilst we acknowledge that there could be practical difficulties in enacting this could have included continuing to operate the PTB as business as usual, albeit with the staff TUPE to Coperforma. The PTB operation could then have been gradually phased out as the new call centres became proficient and experienced with the delivery of services in Sussex. Also, SECAmb could have been invited to provide transport as required for a short interim period, whilst Coperforma ensured all of its sub-contractors' drivers were

fully trained, PDA's issued, Trust staff issued with system passwords and the appropriate number of vehicles were available in the right locations.

31.12 At the Introductory Meeting between the CCGs and Coperforma on 26 November 2015 the CCGs stated their intention to discuss the potential for a phased transition. HWLH CCG has advised that a phased implementation was not considered necessary because they had received assurances from Coperforma that all of the required actions had been completed to facilitate full mobilisation on 1 April 2016. We understand that retaining the PTB after 1 April 2016 would also have been problematic due to staff reductions experienced during the last few weeks of the service, which had resulted in limited available capacity.

31.13 In a letter to the Accountable Officer at HWLH CCG, dated 7 December 2015, SECAmb stated that they did not want a phased transition, and that a full handover of services was expected on 1 April 2016.

31.14 The booking system operated by the PTB belonged to HWLH CCG. Consequently, it would appear that the systems infrastructure to implement a phased transition of the PCS system was present. However, at 23:00 on 31 March 2016 the PTB booking facilities at the Durrington office were switched off and the ICT equipment was removed. We suggest that this then precluded any opportunity to revert to a phased implementation of the new arrangements, however we acknowledge by this time it would have been too late to have put in place the necessary links for this to interface with Coperforma's booking system.

Recommendation: 9	Priority: 2
Consideration should be given to including within the contract specification for major contracts where significant service changes are anticipated that a phased transition approach by bidders would be welcomed.	

Monitoring the key operational 'go-no go' elements of the new service

31.15 There were a number of key operational aspects of the Coperforma service delivery model, each of which were fundamental to being able to provide a fully fit for purpose service from 1 April 2016. It is noted that whilst these key operational aspects required for the successful delivery of the service were individually raised either by the CCGs or Coperforma during the mobilisation phase, there does not appear to be any connecting up of these aspects to obtain a bigger picture perspective. As the Coperforma solution is dependent upon ICT solutions, which were not previously in place in Sussex, there should have been much more robust monitoring, both collectively and individually, of these key operational elements of the service.

31.16 The mobilisation phase was conducted in a mutual assistance, rather than an adversarial, manner. The CCGs were working in an open and constructive manner to facilitate a seamless and successful commencement of the new contract. We understand that a constructive dialogue has been used successfully by HWLH CCG on a number of other major contracts. Throughout the mobilisation stage Coperforma therefore had ample opportunity to raise any concerns regarding practical issues emerging, with a reasonable expectation that HWLH CCG would work with them in a constructive manner to resolve them. The effectiveness of a constructive dialogue approach is reliant upon all parties being open and transparent.

Reliance upon assurances from Coperforma

31.17 Coperforma's initial Risk Statement included three core assurances in relation to a successful mobilisation. For each of these we have considered whether Coperforma raised any concerns in these areas with HWLH CCG prior to 1 April.

- **Readiness Audits:** *Three formal audits from Coperforma "peers" to the Mobilisation Team, to support the team and determine if anything may have been overlooked or that could be a risk to a successful implementation.* We have only had sight of one of these Readiness Audits. This was provided to us by Coperforma and comprised of a single side of A4 and it does not indicate who carried out the audit. HWLH CCG has advised that Coperforma was expected to submit readiness audits within its weekly dashboards, but that these were provided as part of progress updates within the presentations submitted to the Programme Board, rather than as standalone reports. HWLH CCG has advised that in the month leading up to the contract commencement Coperforma did not indicate these independent audits had highlighted any significant issues or concerns which may impact on their readiness to deliver from 1 April 2016.
- **Data Quality:** *Coperforma will obtain incremental weekly transfers of all patient bookings from SECAmb. This will eliminate the data quality risks that have been identified and enable the Patient Transport Bureau/Hub to become operational in January 2016. This will enable renal Dialysis patient bookings to be transferred to eliminate the risks to patients and avoid disruption for clinical teams.* We understand there was no weekly incremental data transfers, and HWLH CCG has advised that in the month leading up to the contract commencement Coperforma did not indicate the absence of these weekly transfers had caused any significant issues or concerns which may impact on their readiness to deliver from 1 April 2016. Furthermore, we have seen no evidence that Coperforma raised any concerns with HWLH CCG that the initial year's worth of data transferred by the PTB was so incomplete as to preclude Coperforma from being ready to deliver on 1 April 2016.
- **Staff Transfer:** *Poor or late engagement by the current contracted provider. Creating unnecessary anxiety for staff, delays their access to vital update training and threatens the 'go live date'. The mitigating actions advised were: managing the current Provider closely so that any slippage is clearly identified and managed; engaging with staff-side representatives at a national and local level to access staff; and having sufficient contingent transport capacity to run the service without any of the TUPE staff.* HWLH CCG has advised that in the month leading up to the contract commencement Coperforma did not raise any significant issues or concerns relating to staff transfers which might impact on their readiness to deliver from 1 April 2016, and on a number of occasions repeatedly confirmed there were sufficient resources earmarked to cover situation if no staff actually TUPE transferred.

Assurances obtained directly by CCGs

31.18 We have seen no evidence of any mobilisation meetings being held at Coperforma sites, or any checks by HWLH CCG to evidence that both Coperforma and its sub-contractors were ready and validate the assurances being given by Coperforma. There does not appear to have been any independent checks commissioned by the CCGs to confirm that assurances being provided by Coperforma were robust.

31.19 We were advised that the only representatives from HWLH CCG to visit Coperforma's office who viewed the PCS in operation were from the PTB. There appears to have been no formal feedback from that meeting, which we understand was principally for discussing the transfer of the PTB staff to Coperforma.

31.20 It was advised that whilst the contract/service evaluation panel included clinicians, patients and experts in areas such as IT, this panel did not include any officers with particular expertise in transport or patient transport operations.

31.21 CCGs are relatively small organisations in terms of number of staff, and it is clear that the mobilisation for a new contract can be labour intensive. This PTS contract reinforces the need to consider engaging independent consultants to manage the mobilisation phase of large contracts where new arrangements are being introduced.

Recommendation: 10	Priority: 2
Consideration be given to commissioning independent consultants to monitor and advise on the mobilisation for major contracts where significant service changes are anticipated.	

31.22 **Assessment:** There are number of lessons to be learned for future major projects which entail significant change in how the service will be delivered. The key lessons include:

- Engage a suitable independent professional consultant to oversee the technical aspects of the service.
- Ensuring there is a 'Plan B' (contingency plan) in place for all major procurements.
- Utilising a phased implementation where possible on any major procurements where there are significant changes to the contract and/or the service delivery model.
- Need to have in place a robust monitoring process to provide independent assurance to both the CCGs and the new provider that services will be ready to operate in accordance with the contract specification from the first day of the contract.

CONCLUSION

32. The Sussex CCGs took a constructive dialogue approach to engaging with Coperforma during the PTS mobilisation process, an approach which has been successful on other contracts. The period of time between contract award and contract mobilisation was not unreasonable when compared with other patient transport services contracts let by other CCGs, however there appears to have been a slower than originally intended start by Coperforma which provided less time to demonstrate they were going to be ready to fully deliver from 1 April 2016. From the information we have been provided with, Coperforma was clearly very positive and confident throughout the mobilisation process that there would be a seamless and successful

transition on 1 April 2016 without the need for any phased/staged transfer. Given the resulting failure to meet the required service standards, which were still not being met six weeks later, this confidence would appear to have been misplaced. Coperforma has advised us verbally that despite slippages in their timetable as set out in their original mobilisation plan they did not raise any major concerns about being fully ready for 1 April 2016. We consider that patient welfare needed to be the paramount consideration in any decision to confirm readiness to deliver.

33. We suggest that there are a number of factors which collectively created a situation whereby there was an insufficiently tested Sussex-wide infrastructure which was expected to be able to seamlessly bed in after the contract start date without any adverse impact on service delivery. Without a period of parallel running prior to the contract start date the potential impact on service delivery and patient welfare of the combination of these factors, which can be now be seen in hindsight, would not have been so evident in the immediate run up to the contract start date. The service delivery issues subsequently experienced during April and May 2016 and in particular the failure to adequately factor in the conflicting demands of simultaneously servicing six Trusts from the first day of the contract indicates Coperforma should have been less confident and should have considered making a request to the CCGs that a phased implementation be considered, even if this was only days before 1 April 2016.

34. When adopting a constructive dialogue approach to future service changes, the Sussex CCGs may wish to consider requiring more tangible evidence of preparedness from providers (especially new ones) rather than accepting written and verbal assurances. HWLH CCG does not employ a professional patient transport expert, and it would have been appropriate to consider engaging one to oversee the mobilisation process for a contract of this scale and complexity. This expertise would also provide the critical independent friend role that we suggest would have benefited both the CCGs and Coperforma, and they would have been able to identify whether the confidence of Coperforma was demonstrably underpinned by supportable and sustainable evidence.

HOSC 2016/17 Work Programme

25th May 2016 – Has been held

Agenda Items	Invited
HOSC TOR	
HOSC Work programme 16-17	
South East Coast Ambulance (SECAmb) Red 3 Triage	SECAmb
Ambulance to hospital handover	SECAmb, BSUH
Suicide prevention	Public Health, SPFT, Grassroots
NHS patient transport	HWLH CCG, Coperforma

20th July 2016 – has been held

Agenda Items	To be invited
GP Sustainability and Quality	CCG, CQC, NHSE
GP Services in Brighton & Hove: Healthwatch Perspective	Healthwatch
SECAmb: publication of Monitor report on patient impact of Red 3 Triage scheme	SECAmb
Ambulance to hospital handover	SECAmb, BSUH
NHS Patient Transport: July 2016 update	HWLH CCG, Coperforma

05 October 2016 – Special Meeting – has been held

Agenda Items	To be invited
CQC Inspection Report: Brighton & Sussex University Hospitals Trust	BSUH

19 October 2016 – proposed

Issues	To invite
CQC Inspection Report South East Coast Ambulance Trust	SECAmb
Stroke: Regional Review of Stroke services – update on regional review	Sussex Collaborative
Patient Transport (to include independent report on tender process and independent audit of performance stats)	CCG, HWLH CCG
Deputation from Full Council: Sustainability & Transformation Plan	

7th December 2016 - proposed

Issues	To invite
6 month update on planning for GP sustainability – including data on impact of previous closures	CCG & NHSE
Healthwatch Annual Report 2015/16	Healthwatch
3Ts development of Royal Sussex County Hospital	BSUH
Substance Misuse Inpatient Detoxification: report back (requested March 16 OSC)	Public Health

1st February 2017 –proposed

Issues	To invite
Update on dementia services i) Planned move back into single sex dementia beds for the acute in-patient service ii) Strategic approach, diagnosis & memory assessment	ASC, CCG, SPFT
Still births and Multiple births	
Mental health & delayed transfers of care	

22nd March 2017 - proposed

Issues	To invite
Diabetes	
Functional mental health and older people	

Additional Issues (dates TBC)

- Outpatients (if not a major part of CQC inspection report)
- MH pathways from diagnosis through treatment
- Access to information about city health and care services
- ASC performance

Workshop(s)

1. Children & young people – mental health and wellbeing