NHS
High Weald Lewes Havens
Clinical Commissioning Group

STATUS: PUBLISH

REPORT: A REPORT OF THE PATIENT SAFETY GROUP

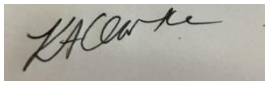
DATE: 04/01/2017

Owner: sarah.richards2@nhs.net
Version Control and Copy Requests: dee.coffey1@nhs.net
Version / Date: 20170104

PATIENT SAFETY GROUP (PSG) MEMBERS

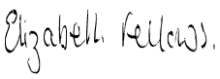
Kathryn Campling
Head of Governance
Coperforma Ltd

Allison Cannon
Chief Nurse
NHS Hastings and Rother CCG
NHS Eastbourne, Hailsham and Seaford CCG



Kellie Clarke
Local Authority Designated Officer
East Sussex County Council

Angela Cole
Lead Nurse Dialysis
Brighton and Sussex University Hospital Trust



Elizabeth Fellows
Assistant Director of Delivery
East Sussex Healthcare Trust

Gillian Field
Designated Adult Safeguarding Nurse
NHS High Weald Lewes Havens CCG
NHS Hastings and Rother CCG
NHS Eastbourne, Hailsham and Seaford CCG

Elizabeth Mackie
Community Engagement Manager
Healthwatch East Sussex

Benita Playfoot
Interim Quality and Risk Manager
Coperforma Ltd

Dr Sarah Richards
Chief of Clinical Quality and Performance
NHS High Weald Lewes Havens CCG

Amelia Stetcher
Lead Project Support
South East and Central Commissioning Support Unit

TABLE OF CONTENTS

1. FOREWARD

A multi-agency Patient Safety Group was established to lead a review into the impact on patients due to failings of the Sussex Patient Transport Service (PTS) in the first 3 months of the contract, which started on 1st April 2016.

High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG), on behalf of the Sussex Clinical Commissioning Groups, had a responsibility to make sure appropriate action to safeguard the safety of patients was taken, and to ensure that this review was managed in accordance with national policy, guidelines, frameworks and best practice.

Over 5000 patient journeys a week are carried out by PTS, and while it was not possible to speak to all the patients involved, the Patient Safety Group, led by a local GP, chose those groups of patients who were most likely to be impacted by problems with the service. These included patients undergoing renal dialysis or cancer treatment where multiple outpatient appointments were required, and those with chronic diseases, Learning Disabilities or Mental Health concerns. Patients in these groups, and the staff caring for them, were interviewed and allowed to discuss their concerns and experiences in an open manner.

Complaints and hospital incidents were also analysed to get a wide a view as possible of the incidents from April to June.

The key finding reported is that there was ***no evidence*** of ***actual physical harm*** in the patients that have been identified and reviewed. However, it **must not** in any way be underestimated that the degree of anxiety and stress, which is **psychological harm**, that these patients and staff have experienced was significant.

It must also be noted that physical harm has been averted by the sheer hard work and dedication of a number of staff (within a number of providers) who have worked extra hours and beyond their job descriptions to ensure that patients received the treatments they required.

A “snap-shot in time” review was carried out in September to ascertain if improvements made (as demonstrated in this Report) have been sustained. The results of this demonstrate that improvements have been, and continue to be made.

The report concludes with recommendations for the PTS, the CCG and other commissioners, providers and the wider NHS, including the local Healthwatch (the independent patient voice) who will be undertaking further reviews of the service now and in the future.

On behalf of the Patient Safety Group

Dr Sarah Richards
Chief of Clinical Quality and Performance HWLH CCG

Elizabeth Mackie
Healthwatch East Sussex

2. INTRODUCTION / BACKGROUND

On 1st April 2016, the Sussex Patient Transport Service (PTS) was transferred from South East Coast Ambulance (SECAmb) to Coperforma Ltd, the new managed service provider. From the start of the new contract, significant issues and concerns were raised by patients, carers, families and NHS healthcare providers. Concerns were around patient transport, as transport was arriving late or not at all for healthcare appointments, and for taking patients home again or to other venues.

On 4th April 2016, a level 3[1] Serious Incident (SI) was raised by High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG), on behalf of the seven clinical commissioning groups across Sussex, and a clinical review analysing and categorising incidents raised by hospital trusts regarding PTS was completed by the Senior Quality and Patient Safety Manager (Habben J, 2016).

The Patient Safety Group (PSG) was set up in early August 2016 to respond to the needs of patients who may have been affected by the issues arising from the problems with the PTS at this time. This included the identification of patient groups and individuals who may have been affected and ensuring that appropriate follow up and support was in place and available to meet their needs.

3. THE PATIENT SAFETY GROUP (PSG)

Firstly, it was important that the work of the PSG was managed in line with National Guidance in the management of incidents of this nature, such as the Serious Incident Framework. To support this approach, a Decision Process Map was created, describing the inter-relationship between the work of the PSG and National Guidance. This is available on request to the HWLH CCG.

The three key objectives identified by the PSG were as follows:

3.1 To gather evidence of potential harm to patients, as a result of failures within the PTS;
3.2 To identify, and make recommendations on areas where further service improvements are needed, to assure patient safety in the future;
3.3 To support the Investigation Group should further non-clinical investigation be required.

[1] The investigation was conducted in line with the NHS England Serious Incident Framework (2015). This framework provides a structure for investigating any event where the potential for learning or the consequences to patients, families and carers, staff or organisations is significant. A level 3 investigation is defined as "Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/capability of the available individuals and/or number of organisations involved".

Membership of the group was carefully considered to ensure appropriate representation from the clinical commissioning groups, the main provider trusts, experts in safeguarding patients (both NHS and Local Authority), the PTS provider Quality and Risk Manager, and a representative from Healthwatch, as keen advocates for patients and patient care. This was to ensure patients were at the centre of the work that was done, and worked closely with the HWLH CCG Quality team.

The PSG was chaired by the High Weald Lewes Havens CCG Chief of Clinical Quality and Performance, a GP and member of the CCG Governing Body, and a deputy was nominated: the Interim Quality Risk Manager, Coperforma Ltd.

Terms of Reference for the Patient Safety Group can be found at **Appendix One.**

The PSG's first priority was to make an assessment regarding whether patients had experienced any *harm*, and if so, the impact of this and what support they needed. Secondly, the Patient Safety Group focussed on the *experience* of patients using the service, so that any key issues could be identified, and recommendations to improve the service could be made.

4. METHODOLOGY

The detail regarding the methodology the PSG used is available in **Appendix Two**. This describes a 3 phased approach to investigate whether harm had occurred, and/or the experience of patients had been adversely affected.

Phase one concentrated on gathering evidence from a number of sources; Phase two focused on bringing all the information together, cross referencing and analysing it, and Phase three is this report – giving the key findings and identifying areas to improve the service in the future.

The group looked at the incidents logged in the clinical review described earlier in this paper. Incident reporting systems are used by all hospital trusts using patient safety and risk management software to enable review of incidents and to ensure learning from the incidents occurs. It should be noted that the system used looks at *potential* and not *actual* harm and shows the trusts where further review is required. Of the 900plus incidents – 190 were deemed to be of moderate or severe harm as defined below.

PTS Clinical review - assessment of harm (Habben, J 2016) - adapted from National Patient Safety Agency 2011

Level of Harm	**Example of Review/Calculation of Harm**
Moderate Harm	All renal patients who have experienced disruption, psychological harm, missed appointments or had a reduced treatment time (haemodialysis) due to a either no provision, or a delay with the provision of patient transport. All oncology patients* who have experienced disruption, psychological harm and missed appointments due to either no

	provision or a delay with the provision of patient transport. *'*category 1 patients have rapidly growing tumours, being treated with radical intent. The effects of interruptions on the outcomes of these cancers have been assessed by a number of studies. Treatment duration must not be prolonged by more than 2 days over the original prescription'.* *RCR standards 2008.* A patient who has missed more than one medical appointment due to lack of patient transport. A patient who has missed one medical appointment following the 2/52 referral pathway for suspected cancer due to lack of patient transport.
Severe Harm	A patient who may have missed multiple oncology or renal appointments due to lack of patient transport. A patient who has been admitted for emergency medical treatment due to lack of patient transport.

Further detail was provided by the Acute Trust involved, and the information cross-referenced with other sources of data – for example complaints received and other forms of incident reporting.

Interviews were then carried out with renal patients, oncology and other units as described below.

We also looked at complainants, patients who did not attend (DNA) their outpatient department appointments (OPD) and the Care Quality Commission (CQC) data.

Initially, a formal approach to interviewing patients and staff was considered, through the use of tailor-made, semi-structured interview schedules. However, on reviewing the draft proposed interview schedules, the overarching Incident Co-ordination Group (ICG) discussed the merits and shortfalls of such an approach. They concluded that an "open" style of dialogue should be used, similar to that used in Discovery Interviews (NHS Improvement, 2009) rather than use of a formal, semi-structured template. It was considered that the less formal approach would enable patients (and staff) to talk freely about their experiences of using PTS, in an unconstrained manner.

An important step was identified by the PSG: this was a built-in mini-review of the methodological approach used, and was repeated at strategic points throughout the PSG enquiry into potential patient harm, and patient experience. For example, after the site visit to the Renal Unit, the lead interviewers discussed the approach used, and determined whether it had been successful in meeting the identified objectives. This was deemed to be important, so that any issues in approach could be addressed, and improvements to the approach made, as necessary, prior to future visits.

5. FINDINGS

5.1 Patient and Staff Interviews / Site Visits

A. Renal Patients

The Renal Unit was chosen as the first unit to contact because from the clinical review it was identified that these patients were most likely to have been affected, due to the nature of their treatment – they have dialysis three times a week over a long period of time.

10 patients were identified by the Lead Dialysis Nurse at the Royal Sussex County Hospital as patients who had been impacted most by the PTS issues, with multiple journeys disrupted – i.e. having moderate harm as defined by the incident reporting system.

The PSG and CCG Clinical Quality Manager also visited the Crawley and Eastbourne Satellite Dialysis Units. In total 12 patients were interviewed here, together with members of staff including booking staff, unit managers and ward sisters. The 12 patients were agreed as being representative of renal patients, and there was a high degree of consistency in their statements when interviewed.

As part of the discussions with patients, they were asked directly if they felt that they had come to any physical harm. None reported feeling that they had come to physical harm. However, a number of patients reported feeling anxious and stressed by the PTS issues. Their treatment took a large amount of time out of their day, and delays caused by *"waiting for transport"* made the day even longer for them. Patients reported that they found it *"very tiring".*

Clinicians were also asked about whether they believed that any of their patients had come to physical harm, and all reported that they had not. However, it is extremely important to note that this does not in any way underestimate the additional stress and anxiety experienced by patients, at what is already a difficult and stressful time in their lives. Patients could have therefore been said to have experienced psychological harm.

Extra time had been spent by numerous staff members to ensure patients treatments were not altered or shortened, and many staff had stayed much later than their contracted hours to ensure everything was done to ensure patient safety and experience.

Key themes emerging therefore related to the ***patient's experience*****,** as follows, rather than to actual physical harm:

- Patients told us they were often picked up in a vehicle with only themselves in it – yet they knew of other patients living very near them who were attending the same clinic, on the same days /times. Patients queried why they were going separately, when it would make sense that a number of patients travelled together;
- Despite regular bookings, patients nearly always got different drivers – *"never the same driver";*
- Patients were often picked up late, thus arriving late for appointments, although this was reported as having improved significantly from August;
- Patients could wait a very long time to be transported home again, up to 5 hours in one case;
- On Saturdays, delays were particularly experienced in return journeys after treatment had finished;

- Drivers sometimes came from as far away as Nottingham, and Somerset, staying locally for a week at a time to drive patients to and from their appointments. Patients asked us why drivers were not sourced from the local area;
- Patients stated that where they had telephoned to enquire about their transport time of arrival, they were often told that the transport was *"imminently on its way"*, whereas it transpired that this was not the case;
- Difficulty in getting through on the telephone to ask about updates – patients reported that they spent a good deal of time trying to find out information, but sometimes couldn't get through, or were cut off;
- The high use of private taxis to ensure patients got in for treatment and home again;
- A number of patients reported that the overall service had improved within the last few weeks of August.

CASE EXAMPLE: Mrs XX had been attending the Renal Unit for the last two years. Whilst the service *"was not great"* before 1st April: when the contract changed over initially it "*was chaos*". Before, if the drivers had *"space for another……we would travel together but that this does not happen now*". She said *"Sometimes the transport arrives really early – for example 1050 am, but my appointment isn't due until 1230pm. The latest I have been picked up for my 1230 treatment appointment is 215pm! My husband told me that after I had been picked up, a second vehicle arrived at my house ten minutes later! Going home has been a real problem – it means I have no time in the evening: my husband has prepared supper and it is nearly always spoilt. I felt sometimes I was being treated like cattle – I have often said to my friends:* ***"if they were a patient, just for a day……."*** *When you phone up, they don't care, they tell you "it's on its way, your driver is very close now", but when I ask my driver where he has come from, he has come from much further afield…….. They just fob you off".*

B. Oncology (cancer) Patients

The nature of oncology treatment means that the number of patients affected was smaller than that of renal patients. The PSG visited the Brighton and Guildford units and spoke to the oncology sister, senior radiologist and staff. It was also possible to speak to 2 patients who were still having treatment, as they had been on a prolonged treatment regime, and discuss their experiences over this time.

The findings were similar to those above – neither clinicians nor the patients interviewed felt they had been physically harmed, but the patient experience had again been poor and psychological harm (anxiety and stress) had been caused. Also, the PSG noted the extra efforts of the Oncology Unit staff that provided additional and out of hours treatment to mitigate the issues with the transport service.

CASE EXAMPLE

Ms XX has been attending for Radiotherapy for cancer for some time. At the beginning of her treatment she was often late and had to wait for treatment. *"Drivers are always very caring and can't fault this*". However *"transport comes at odd times"* can be picked up at 06:30 for a 13:00 appointment. Missed one treatment as too late so had 2 treatments at end to make up for it. Can make it a long day as has to wait up to 3 hours for transport to come to pick her up again. *"I get very tired".*

5.2 Smaller Service Providers' Site Visits – Patients and Staff Interviews

A. The Bluebell Unit – Burgess Hill

The Bluebell Unit is a recovery support Day Centre for adults with a Mental Health diagnosis. The unit treats at least 28 "members" (patients) every week and each member has set days to attend.

Both members and staff members at the Bluebell Unit told us that delays and issues caused by the transport service exacerbated patients' stress and anxiety levels, in some cases quite considerably, and was therefore another example of psychological harm.

The members at the Bluebell Unit found having lots of different drivers especially difficult, often they did not wear ID badges, and members perceived them as *"unhelpful"* at times. Other themes regarding delayed pick up and returns were consistent with other interviews and patient experiences. They also raised concerns regarding advice given on the phone *"that the driver is minutes away- but takes ages to arrive. We get fobbed off".*

However, all members and staff members agreed that within the last two months – that is, August and September - the service had improved, and was more consistent with less disruption.

B. Specialist Dental Clinic - Eastbourne

The Head of Dental Services and the Coordinator were interviewed to find out about the impact on patients resulting from the change in the contract for the PTS.

This clinic provides a number of services – both diagnostic and treatment – within the one clinic, for patients who have complex and multiple health needs. It is unique in the fact that a single patient can attend the clinic to undergo a series of tests and investigations – such as blood test, x-rays, scans, as well as the dental treatment, all in a single visit.

Also these patients are often accompanied by a carer / escort, owing to the nature of their complex needs.

Consequently, it was reported that, should a single patient arrive late for their appointment, due to the multiple tests and investigations this would impact on the whole of the patient's visit, and cause delays in the clinic as a whole – i.e. making everyone and their investigations delayed. This then had a knock-on effect on carers and escorts accompanying their patient, which was a significant issue.

Due to the complexity of some of these patients, the biggest issue reported at the Specialist Dental Service was the impact on patients' emotional and psychological state – they reported high levels of anxiety and stress, and clearly the effects of this for patients and their carers cannot be underestimated.

A practical issue also occurred at the Dental Clinic – some patients arrived on a stretcher, and – due to the nature of their disability – needed to remain on the stretcher for the duration

of their treatment / visit. However, due to a lack of available equipment, crews had to take the stretchers with them in order to complete another journey.

On the positive side, it was reported that Coperforma Ltd had appointed a "high acuity" team to help them manage these complex, special care patients: Coperforma Ltd had engaged early with the service lead when the service transferred to them, and *"we cannot fault their engagement, support and help"*. Also two specific personnel (service delivery team within Eastbourne District General Hospital) demonstrated immense patience and resilience despite the difficulties, and were described as *"unsung heroes"* by the dental lead.

C. Specialist Podiatry Clinics

Senior staff were interviewed at the Specialist Podiatry clinics in West Sussex. It was reported that prior to April 1st, the transport was *'rubbish'* and patients had a *'bad experience'*. Since April nothing much was reported as particularly changed. It was stated that the key areas of poor practice was patients arriving late for appointments and some missed their appointments completely. Patients were left waiting a long time after their treatment, sometimes up to five hours. The tracking device system was described as *'useless'*, as an ambulance would be showing that it was local, but then moments later showed that it was in Yorkshire. At the beginning of the contract this had affected whole clinics of patients, but had improved to only one or two occasional cases in the last few weeks of September.

In addition to the themes described elsewhere and similarly experienced at the Podiatry clinics, it was highlighted that a diabetic patient with an "at risk" foot would *always* be accommodated whatever time the patient turned up, but it meant that staff extended their working day, or arranged extra domiciliary visits.

5.3 Complaints Data Review

During the time period of this review, 33 patients had made a formal complaint to the HWLH CCG regarding issues around the PTS (01.04.2016 - 15.08.2016). Some complaints were received via a family member or an MP. Contact details and consent were requested and received from 8 of these patients and these patients were contacted by the Chief of Clinical Quality and Performance, HWLH CCG. Once further verbal consent had been obtained, a telephone interview took place.

Of these, one patient's interview responses were not taken into account, as it transpired that the issues raised in fact turned out to be unrelated to the PTS, but to "other" reasons. The Chief of Clinical Quality and Performance re-directed this patient to the appropriate person to follow up their specific issues.

Interviewing a member of Coperforma Ltd staff revealed a second small cohort of a further 5 patients who have had problems with the PTS.

Given the specific information provided regarding these 5 patients, they were all identified as suitable for potential interview / follow up. The Clinical Quality Manager conducting these

interviews was unable to contact one of the five patients, leaving 4 for whom in-depth telephone interview was conducted, following confirmation of consent.

The key themes emerging from the telephone interviews conducted very much reflected those found through interviewing patients in person at the units visited, as described in Section 5.2; these will not therefore be repeated here. Also the patients who had complained were consistent with the patients identified in the incident reports and included renal, oncology and mental health patients, plus a number who had chronic health problems necessitating on-going outpatient care.

5 of the 7 patients in the first cohort talked about the severe difficulties in getting through to a member of staff on the telephone, with long delays in getting through, and once again being given false assurances that *"transport was imminently on its way".*

One new theme emerged however regarding patients who had to have a very early morning pick up (for example, as early as 6 am) to go to an out of area hospital, such as King's College Hospital, London. When the transport did not arrive, the patient or their relative would try to ring to enquire as to the arrival of transport, but the telephone did not open until 0700, so it was impossible to contact anyone. This understandably caused frustration and anxiety for patients.

Regarding the second, smaller cohort of patients identified by the Coperforma Ltd member of staff, all 4 patients described how problems with the PTS had caused them considerable anxiety and stress, at a time in their lives which was already stressful, due to the health issues they were experiencing.

All 4 patients had resorted to sourcing other means to enable them to attend their appointments for treatment – three used private taxis extensively, and one relied on family to take him as the service could not be relied upon. One patient had spent £17.00 on a taxi to Crawley, and £60.00 to get to Guildford, for treatment.

5.4 Did Not Attends (DNAs)

The Business Intelligence team at East Sussex Hospitals Trust looked at the data for April and May 2016 that related to patients who did not or could not attend their outpatient appointments. Once other reasons and rescheduled appointments were eliminated the remaining patient data was cross-referenced with information held by Coperforma Ltd to identify out of these, how many patients did not attend their appointment due to issues with transport.

As an example in April 2016 there were 579, from a total of 3563 appointments, that could not be accounted for at that stage (although some may still have been awaiting reappointments)

Of the 579 it was found that 13 patients were categorised as "DNA" due to transport problems. These were 1 new patient and 12 follow-up patients.

For May it was found that 10 patients – i.e. 4 new patients and 6 follow-ups.

Smaller numbers were seen in June.

ESHT Assistant Director of Operations has since contacted all of these patients, and made sure their appointments have been rebooked. Therefore no further contact has been made by the PSG.

As the work involved in finding these patients from an original list of 3563 was extensive for the trust, and because there was no indication that further such analysis would result in different findings, it was decided not to roll this methodology out across the other trusts. It is possible however that the difficulties accessing the Demand Centre may have prohibited patients booking transport, although this cannot be quantified.

5.5 Review of Incidents Reported via the Incident Reporting System

Data was obtained from the local trusts, with the focus on renal patients and oncology patients, as previously explained. It is important to note that incidents reported via this system are those which *may result in potential physical harm* to the patient, at certain levels. This gives an indication of the need to look further at cases to establish if *actual harm* has occurred.

From the clinical review carried out in July 2016, it was identified that, out of a total of 980 incidents, 3 patients may have experienced potential severe harm, and 187 patients may have experienced potential moderate harm. It is important to note that these figures are conservative, as under-reporting of incidents due to many factors – as described in the clinical review paper – is likely.

The following table shows from which sites these incidents were reported:

Level of Harm / Site	HWLH CCG	RSC	SCFT	SASH	ESHT	BSUH	WSHT	TOTAL
SEVERE	**1**	**2**	0	0	0	0	0	**3**
MODERATE	0	0	**16**	**2**	**49**	**75**	**19**	**187**

Key: *HWLH CCG – High Weald Lewes Havens CCG; RSC – Royal Surrey County Hospital; SCFT – Sussex Community Foundation Trust; SASH – Surrey and Sussex Hospitals; BSUH – Brighton Sussex University Hospitals; WSHT – Western Sussex Hospitals Trust.*

The HWLH severe harm was the level 3 incident described at the beginning of the report

The NHS treats the protection of patients' confidential and identifiable information (Patient Identifiable Data, PID) extremely seriously, and there are strict safeguards in place which limits the sharing of such data.

Therefore, all Quality Leads at each of the above were contacted by the Chair of the PSG asking for PID to be shared with the group, which is allowable under specific rules where it is considered patients may have come to harm and / or there are safeguarding concerns.

All but two trusts were able to share their data appropriately in this way. The two that were unable were Sussex Community Foundation Trust (SCFT) and the Royal Surrey County Hospital (RSC). However, in respect of the first – SCFT – most of the patients were likely to be renal patients, and therefore already captured as part of the site visits (see 5.1(A)). RSC

was unable to find data on their system that corresponded to the known incidents and so could not send any PID.

In order to ensure that the PSG did not miss any important new information, the Chief of Clinical Quality and Performance undertook further site visits to the Royal Surrey County Hospital, as both incidents involved oncology patients.

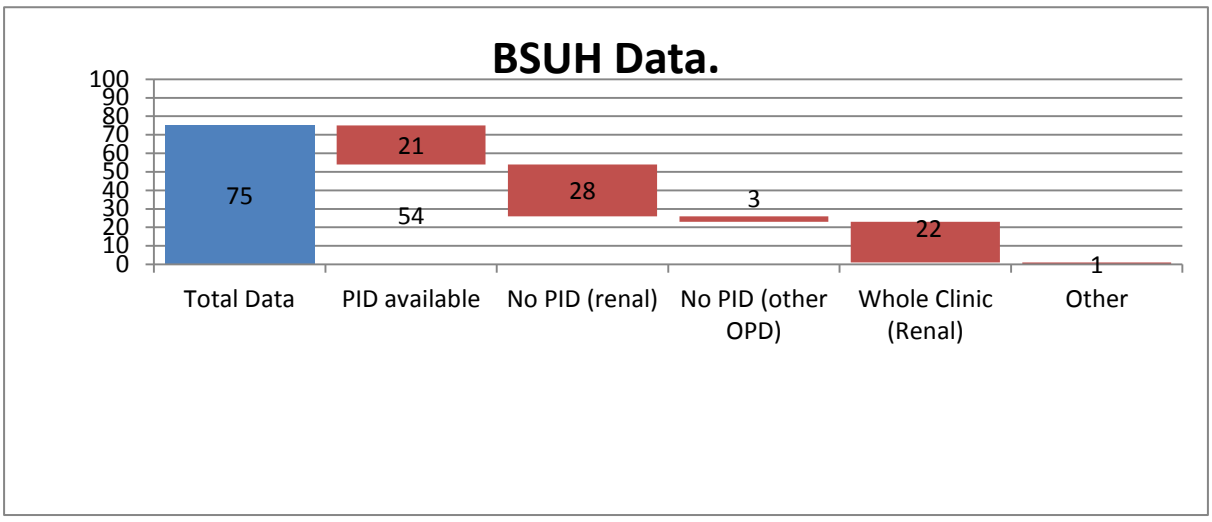
Excluding the two trusts mentioned above there were a total of 145 patients across the four remaining trusts (i.e. BSUH, ESHT, WSHT and SASH: the numbers in the above table).

This data was then cross-referenced with data held by Coperforma Ltd, so that the reasons for the patient transport issues could be investigated.

A. BSUH

In total, out of the 75 incidents, all but 2 related to renal patients.

The number of incidents with available data to review became 21. This was due to the fact that patients were often put onto the system as “whole clinics”, with patient initials only, the PID not being available to BSUH themselves. This was particularly seen for incidents from the Eastbourne satellite Renal Unit. The Chair therefore visited this unit to ensure that nothing was missed.



It was documented that 5 of these (renal) patients had died: however, the chair reviewed these cases with the Lead Dialysis nurse at Royal Sussex County Hospital (RSCH). It was felt these deaths were in very frail, end-stage renal failure patients with multiple co-morbidities, and transport delays were not the cause of their deaths.

One (oncology) patient who was due to be transported from the Princess Royal Hospital to RSCH died, but this was not as a result of failings with the transport service. This patient was extremely frail and ill, with multiple complex healthcare needs, and was felt to be too ill to travel at this time. She was an inpatient at the time.

B. East Sussex Healthcare Trust (ESHT)

At ESHT, as seen in Table One above, there were 49 incidents in total, and these were found to be as follows:

- One whole clinic (8 patients) at the Tunbridge Wells Hospital at Pembury missed their DXT;[2]
- 18 patients missed their routine outpatient appointment (OPD) more than once: these were all re-booked;
- 9 patients missed their radiotherapy (or it was delayed), and a further 8 missed Two-Week-Wait appointments: again, these were all rescheduled;
- 3 patients arrived late for their dialysis treatment;
- 3 cancer patients missed their outpatient appointment or investigation;
- 6 patients were late for their podiatry appointments;
- 4 missed physiotherapy sessions.

A further renal patient had died. However, this occurred three months after the patient missed dialysis treatment, so it is unlikely that the patient's death was directly related to transport issues.

The missed radiotherapy treatment was discussed with the senior radiotherapist and all patients were rebooked – their treatment would have been extended by 1 day to ensure the entire course was completed.

C. SASH

There was only one patient's detail entered onto the system at SASH – although there were two entries.

This was a patient who had been late for his dialysis.

D. WSHT

At WSHT, there were a total of 16 incidents, broken down as follows:

- 4 patients were delayed in getting their investigations;
- 2 patients experienced delayed dialysis;
- 3 delayed cancer OPDs;
- 2 delayed Two-Week Wait appointments;
- 3 patients had their Pre-Assessment Clinic OPDs delayed;
- 1 delayed cardiac procedure; and
- 1 patient's chemotherapy was delayed.

Themes were similar to other sources of information, but two new themes did emerge, these were:

- Where the transporting vehicle needed to transfer a patient using a wheelchair
- Difficulty in transporting bariatric patients, due to lack of the appropriate vehicle being available.

[2] DXT – Radiotherapy, for the treatment of cancer and tumours.

5.6 The Care Quality Commission Data (Complaints)

As a result of information raised by a member of staff from Coperforma Ltd to the Care Quality Commission (CQC), the CCG contacted the CQC to find out more information regarding the complaint raised.

As part of this enquiry, it came to light that a number of complaints had been made – directly to the CQC – in relation to the PTS. These were from both patients and staff (that is, staff from other NHS and Social Care organisations who were reporting on the poor quality of the PTS, as affecting their patients). There were 32 complaints received during the period reviewed. 4 complaints raised were from currently employed by or former staff of Coperforma Ltd, and 1 working for a sub-contractor of Coperforma Ltd.

Unfortunately, due to rules around the sharing of PID (patient identifiable data) previously discussed, the CQC were unable to share PID which meant that further follow up of the patients identified as a result of the risk assessment could not take place (i.e. there were no names, contact details available).

However, given the detail (non PID) documented within the information provided by the CQC, it was relatively straight forward to recognise similar themes as to that found elsewhere. There was no evidence of any new concerns coming to light through this data interrogation. Also, CQC had directed these complaints to either HWLH or Coperforma Ltd. As complaints were consistent with the complaints already reviewed, it was agreed by ICG not to pursue CQC complaints further.

6. SUMMARY OF THE KEY THEMES

A summary of the key themes resulting from all the review work conducted by the PSG is as follows:

i. Delays in picking up patients, significant delays in getting patients home again post-treatment, early morning collections difficult for longer (out of area) journeys, and Saturdays problematic;
ii. Difficulties in accessing the service for booking, information and support – both via the telephone and via the booking portal;
iii. Inaccurate information being given to patients / carers regarding expected time of arrival of transport;
iv. Multiple vehicles carrying only one patient each, despite patients travelling to and from geographically near locations;
v. Drivers brought in from a long distance away – as far as Nottingham and Somerset;
vi. High use of private taxis;
vii. No reports of actual physical harm, but significant anxiety and stress reported;
viii. Specialist vehicles / equipment availability a problem: e.g. stretchers, transport for bariatric patients;
ix. Rumours about the perceived stability of the service;
x. Large proportion of reports that the service had improved significantly within the past month to six weeks – that is, from August onwards;

xi. Communication received from the CCG and Coperforma Ltd about what was happening was often lacking or incomplete which added to the confusion and anxiety;

xii. Potential physical harm was prevented by dedicated staff at the provider trusts who worked beyond their job descriptions and contractual hours to ensure patients received their treatments.

An unannounced inspection carried out by the CQC in July 2016, and published on 1st November 2016, independently concluded with similar findings to those in this report, listing 11 areas where improvement were needed, including:

- The provider must ensure a robust system is in place for handling, managing and monitoring complaints and concerns;
- There must be robust systems in place to asses, monitor and improve the quality and safety of the services provided;
- The vehicles and equipment used by contracted services must be appropriate for safe transportation of patients, including wheelchair users.

7. THE CURRENT SITUATION – SIX MONTH REVIEW (September 2016)

Current Position / Service Monitoring

Healthwatch are following up speaking with patients at the renal units, to continue to monitor that the situation regarding getting to and from the units using the PTS is improving. Additionally, the Chief of Clinical Quality and Performance, HWLH CCG, and the Director of Delivery met with a patient-led forum – to gain feedback regarding the service. There will now be routine monthly meetings in future, so that the situation can be effectively monitored.

Coperforma Ltd now has Specialist Delivery Teams in place at each hospital to support the transport service, which is positive.

HWLH CCG wants to receive sustained feedback from patients that the service has, and is continuing to, improve. Accordingly, the CCG has ensured the following two key measures have been implemented to support the service going forward:

- Coperforma Ltd has introduced a monthly Quality, Governance, Patient Safety and Risk Meeting, the first of which was held in September. This forum allows for all directors and managers to meet and discuss their specific areas, issues and actions taken to mitigate. It is planned that Coperforma's sub-contractors will be invited to attend one of these early meetings to present an overview of the company and all the measures they now have in place, to provide assurance to trusts, the commissioners, and patients themselves;

- A comprehensive programme of training was provided to Coperforma Ltd by the HWLH CCG Quality Team in June and July. This training focussed on Serious Incidents, and Safeguarding Adults Introductory training was also provided to the Coperforma Ltd Management team with the expectation that they will ensure subcontractors and substantive staff receive further training in Adult and Child Safeguarding.

In order to establish whether the "more recent improvements over the past month" reported by patients and staff has been sustained and / or improved further, a "snap-shot-in-time" audit was conducted by the Chief of Clinical Quality and Performance.

Methodology was repeated, as before, for the review of the incident-reporting data for the month of September 2016, across five main trusts: BSUH, ESHT, SCFT, SASH and WSHT.

A total of 92 incidents were interrogated by the Chief of Clinical Quality and Performance, and it is clear that – six months from the date of commencement of the contract on 1st April 2016- significant improvements have been made. This is compared to over 980 incidents for a similar time period in April.

Level of Harm / Site	**BSUH**	**ESHT**	**SCFT**	**WSHT**	**SASH**
Total number of incidents	24	28	12	20	8
SEVERE	0	**1**	0	0	0
MODERATE	**3**	**0**	**1**	**0**	**0**

As can be seen by the above table, there is a significant reduction in the number of incidents being reported, across the above five sites.

The level of potential harm has also significantly dropped, with 1 incident reported as *potential severe harm* and 4 incidents rated at *potential moderate harm.*

Furthermore, the nature of the themes has changed to the following:

A. BSUH

- Of the 24 total incidents at BSUH, 3 were categorised as potential moderate harm (these were renal patients who were not picked up on time);
- 15 of the 24 incidents were delays being picked up to return home
- Still some issues regarding inaccurate information being given to callers checking on arrival time – told transport is on its way when it is not;
- Early morning pickups – one incident reported;
- Specialist equipment such as to transport bariatric patients and wheelchair transfers remained a theme, as before.

B. EHST

- Of the 28 incidents reported at ESHT, 1 was classified as potential severe harm, as this patient had missed 3 x OPD appointments for cancer. This is being investigated as a serious incident following national reporting guidelines, transport issues did count for some of the concerns, but there were also cancelled out patient appointments and cancelled surgical procedures as the patient was too unwell to attend;

- Return journeys (for 17 patients), poor telephone advice and the transportation of bariatric patients, raised as above.

C. SCFT

- Of the 12 incidents, again 1 was classified as “moderate” – this was a patient who missed an OPD appointment for cancer;
- The same themes as the above two sections were replicated at this site.

D. WSHT

- 5 late OPD (department not documented)
- 11 delayed return journeys – one up to 41/2 hours late
- 1 problem with a bariatric patient and wrong ambulance sent
- 3 other – 2 not sure what the concern was as details not entered fully and one regarding the behaviour of a driver.

E. SASH

- 2 missed OPD and the rest delayed return journeys.

The main recurring theme still seems to be poor communication, albeit based on reduced numbers. Callers were frequently still being told that the vehicle is on its way when it was not: in one case the patient was told that the vehicle was outside their door, but it was not.

To a lesser extent, the other two themes were:

- Patients being taken singly in one vehicle, despite geographic closeness of patients being collected for appointments at similar times;
- The wrong transport being sent, this did not meet the patient’s individual needs.

Clearly improvements have been demonstrated according to the snap-shot review conducted by the Chief of Clinical Quality and Performance based on the evidence analysed through the incident reporting system. This is encouraging, especially as it confirmed what patients themselves are telling us about the service more recently. There still remains areas of improvement that need to be addressed however.

8 CONCLUSIONS AND DISCUSSION

The work of the PSG has been detailed enough to enable us to make clear recommendations to assure patient safety and improve the experience for patients using the service in the future.

To recap, the key three objectives identified by the PSG were as follows:

a. To gather evidence of potential harm to patients, as a result of failures within the PTS;
b. To identify, and make recommendations on areas where further service improvements are needed, to assure patient safety in the future;
c. To support the Investigation Group should further non-clinical investigation be required.

Firstly, it is concluded that there was no evidence of *actual physical harm* in the patients that have been identified and reviewed. This was a direct question asked to the patients and staff interviewed, and the cohorts of patients seen in the incident reporting review were comparable to the patients seen. However, it must not in any way be underestimated that the degree of psychological harm that these patients and staff have experienced was significant. Many patients told the PSG and Quality Team of the added concern of whether transport would turn up or not at an already difficult time of their lives.

It must also be considered that the PSG were unable to contact all patients affected by the PTS issues, and this caveat must be taken into consideration about harm. However we did ask every patient interviewed this question directly, and the review looked at patients who had been impacted the most.

It must also be noted that physical harm has been averted by the sheer hard work and dedication of a number of staff (within a number of providers) who have worked extra hours and beyond their job descriptions to ensure that patients received the treatments they required, and if appointments were missed, that they were rebooked in a timely manner.

Actual physical harm was also averted by the high uptake of private taxis used by patients, and the stepping in of family members to transport their loved one to their appointments / for treatment.

Finally, the third objective of the PSG defined above became unnecessary, given that no actual physical harm was found: therefore no further investigation or action needed to be considered.

9 CHALLENGES IN UNDERTAKING THIS REVIEW

During the period that the review was undertaken, the PSG experienced some challenges in progressing the work required. For example, one of the main key challenges which arose was achieving an appropriate balance between *protecting* and *sharing* patient identifiable data, both between PSG members themselves, and externally with other organisations as required (for example, Healthwatch and East Sussex County Council).

This balance is a challenge as the desire for the PSG to be open and transparent in all its undertakings conflicted with the essential need to assure patient (and staff) confidentiality, where patients may have experienced potential harm.

A particular example of this difficulty was in PID being shared by the CQC. This was a critical point in the PSG determining whether it should pursue obtaining further information from the CQC or not, in relation to the 32 complaints. Following the risk assessment of the detailed non-identifiable information provided by the CQC, and the PSG having established a number of recurring key themes within other data sets, this informed the group to not proceed in obtaining further information from the CQC.

In terms of the sharing of information within the PSG itself, given that not all members were employed (and therefore governed) by the NHS, a relatively simple measure of employing a "single point of contact" for all communications between group members was adopted, and the strict use of NHS secure email addresses, were found to be effective measures in mitigating this issue.

Another challenge was regarding the paucity of some of the documentation reviewed, which resulted in limitation in the scrutiny of some of the data, and consequent conclusions drawn. When this was recognised by PSG members, individual judgement and group discussion were applied which enabled logical conclusions to be made, on the evidence available. A particular example of this is the variation in the quality of documentation in the logging of incident-reporting data, across different providers.

Due to paucity in organisational memory at Coperforma Ltd, this resulted in, for example, a lack of clarity regarding their internal management structure. One challenge encountered therefore was the ability of the CCG to gain accurate and reliable information from Coperforma Ltd, during the first four months of the service being in operation.

10. NOTABLE PRACTICE

A number of areas of notable practice are highlighted as follows:

Through the use of their vigorous monitoring and reporting mechanisms, HWLH CCG very quickly picked up and acted upon the issues relating to the PTS: within a matter of days, a robust response to the issues was mobilised, and mitigating actions were taken to ensure immediate patient safety. For example, staff ensured that concerned patients, carers and staff were able to report their immediate concerns via a newly setup and highly monitored NHS secure email account;

Staff working in specific units at the provider organisations are to be commended on their hard work and dedication in "keeping the show on the road", thus assuring that patients' treatments were completed. Staff remained behind long after the usual "closing time" of their unit / department so that patients' treatments were not adversely affected;

Coperforma Ltd engaged early on with providers where specific issues arose to provide support and help where needed;

Coperforma Ltd set up a "high acuity team" at the Specialist Dental Service and Renal Units to support highly complex patients with multiple needs;

The multi-agency approach (reflected in the membership of the PSG) ensured a high level of engagement with affected parties. This highlights the importance of involving the right people from the outset, and that leadership across commissioners, providers and other organisations is paramount;

It was considered highly important to utilise experienced, clinical personnel in talking to patients, and understanding their accounts. After some site visits, the unit managers reported that patients had appreciated the time and attention placed on the issue by HWLH CCG staff, in visiting and listening to patients. It was reported that patients "highly valued" the opportunity to tell those who commission the service how the issues had affected them personally.

11. RECOMMENDATIONS

The resultant key themes which emerged from what patients and staff told us enabled specific recommendations to be made by the PSG, in order to ensure sustained improvements could be made to the service for patients in the future.

Recommendations for Coperforma Ltd:

- To ensure training is provided in the care of patients with special needs, and to recognise the importance of not missing medical treatments and appointments;
- To provide additional training for call handlers, including the need to provide Patients with accurate and reliable information;
- To ensure that sufficient numbers of stretchers, specialist equipment for bariatric patients and other specialist items are available to meet patients' needs;
- To review the telephone system and the booking portal to ensure sufficient capacity to meet demand;
- To ensure an out-of-hours contact number is available, so that patients being collected before 0700 am can obtain information and support if necessary;
- To undertake an analysis of patient flows / journeys to ensure better co-ordination of multiple patients with similar appointment times and geographic locations;
- To improve patient communication and engagement so that service users are aware of the current situation.

Recommendations for HWLH CCG and other Commissioners:

- Early communication / briefing releases so that accurate key messages are shared;
- Increase use of patient forums and meaningful engagement so that service users can participate in service review and improvements;
- Ensuring Clinical Quality and Patient experience is at the centre of every new service commissioned and an integral part of the operational delivery.

Recommendations for Providers:

- Training for personnel using the incident reporting system, in order to enhance consistency in reporting across the NHS: this would have been advantageous for this review of data;
- On-going training of using the booking portal so transport can be requested and amended with ease

Recommendations for the Wider NHS:

- Further national guidance regarding incident-reporting systems and other forms of reporting to promote consistency across the NHS;
- Data sharing and use of PID.

12 ACKNOWLEDGMENTS

On behalf of High Weald Lewes Havens CCG, the Chief of Clinical Quality and Performance would like to thank all the patients, managers and staff across all providers, Healthwatch and CCGs for their active participation in this review. In particular, the Chief of Clinical Quality commends providers for going over and above the call of duty in making sure that patients' treatments were not adversely affected, as evidenced in this report.

13 REFERENCES

Clinical Quality Commission (2016), ***"Coperforma Demand Management Centre – Quality Report",*** November 2016;

Habben, J (2016), ***"Patient Transport Service – Clinical Review of Patient Safety Incidents Reported from 1/4/2016 – 15/6/2016"***, Page 7;

NHS England (2010), ***Serious Incident Framework – "Supporting Learning to Prevent Recurrence",*** updated March 2015;

NHS Improvement (2009), ***"A Guide to using Discovery Interviews to Improve Care: Learning from Patient and Carer Experience"***

APPENDIX ONE

NHS
High Weald Lewes Havens
Clinical Commissioning Group

Terms of Reference Patient Safety Group (PSG)

The PSG is established to respond to the needs of the patient population who may have been affected by the failure of the new patient transport service to provide an adequate service to meet patient demand from the initiation of the contract. This includes the identification of patient cohort(s) and individuals who may have been affected and ensuring that appropriate follow up and support is in place to meet these needs.

Accountable to:	Incident Co-Ordination Group (ICG) – with all communication to be copied into Project Support Unit (PSU) at secure email : **HWLHCCG.operationwealden@nhs.net**	
Communication path:	All communication to be via secure NHS net email All communication to be copied into PSU email address **HWLHCCG.operationwealden@nhs.net**	
Reporting:	Adhere to the reporting arrangements set out by ICG within the specified timeframes, as directed. Responsible for identifying, reporting and managing risks or issues related to this work stream via reporting to ICG. As urgent to ICG if work uncovers an area of concern to patient safety.	
Membership:	**Name/Role:** • **Chair**: Chief of Clinical, Quality and Performance, HWLH CCG	**Secure email address:** sarah.richards2@nhs.net

	• Chief Nurse, NHS Hastings and Rother CCG , NHS Eastbourne, Hailsham and Seaford Exec Safeguarding Lead • Assistant Director Delivery, ESHT • Lead Nurse, Dialysis BSUH • Interim Quality Risk Manager, Coperforma **(Deputy Chair)** CoPerforma Quality Lead Lead Project Support, SESCU • Designated Officer Safeguarding, ESCC • Designated Nurse Safeguarding, HWLH • Healthwatch Representative All individuals going on leave to identify a Deputy or take responsibility for escalating.	allison.cannon@nhs.net lizfellows@nhs.net angela.cole@bsuh.co.uk Benita.playfoot@coperforma.co.uk Kathryn.campling@coperforma.co.uk amelia.stecher@nhs.net kellie.clarke@eastsussex.gov.uk gillian.field@nhs.net elizabeth.mackie@healthwatcheastsussex.co.uk
Quoracy	A quorum shall be at least the Chair or Co-Chair and 2 others one of which should be a Director or Deputy Director member of the group.	
Frequency of meetings:	Weekly unless agreed by the Chair, and / or urgently at the request of any member to the Chair.	

PSG Key Deliverables:

1. **Priority One – Patient Safety**

1.1 To agree the methodology to make assessment of harm to patients and the associated safeguarding implications, according to agreed cohort(s) of patients, and based on number of patients affected and assessed severity of harm

1.2 To review and triangulate all available evidence (for example from Incident / Serious Incident Report, Safeguarding data)

1.3 To cross reference / incorporate data with the output from the investigation being conducted by the Provider
1.4 To advise **the Investigation Work -stream** as a matter of priority, providing evidence for further action, as deemed necessary by the Investigation Group
1.5 To advise the **Communications Work-stream** as to the balance of risk/benefit in proactively contacting the cohort(s)or individual patient populations identified above, and any recommended exclusions (**NB:** our working assumption is there will be no exclusions, but that all contacted patients will have been risk assessed for potential follow-up support as needed)
1.6 To review the Methodological approach at key milestones – i.e. after review of each individual cohort – to adapt and build improvement into approach utilised
1.7 To define a comprehensive, evidence-based and scalable therapeutic response to cohort(s) of patients that has yet to be fully identified, as above
1.8 To make recommendations for immediate and future protection of patients where risk is identified, by way of formal, written reports; this is likely to included recommendations for Commissioners, Providers, and Regulators at local, regional and national levels, as applicable.

2. Priority Two – Patient Experience

2.1 To identify patient groups affected
2.2 To design an approach to engage patients and families/carers
2.3 To establish a Family liaison function
2.4 To receive reports and updates from patient and user focus groups
2.5 To report findings and make recommendations to improve patient experience of using Patient Transport Services.

3. Other:

3.1 To agree a Patient Safety Action Plan – detailing the key deliverables as defined above, including timescales;
3.2 To identify resources required to support this work-stream (either in full or in part), and to submit agreed expenditure for entry onto the Project Support Expenditure Log.
3.3 To ensure actions from the Clinical review are included in the above work and escalated as appropriate.

Appendix Two

PSG Methodology

EXECUTIVE SUMMARY

A multi-agency Patient Safety Group has been established to lead a robust review into the recent failings of the Sussex Patient Transport Service (PTS).

High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG), on behalf of the Sussex CCGs have a responsibility to make sure appropriate action to safeguard the safety of patients is taken, and to ensure the review is managed in accordance with national policy, guidelines, frameworks and best practice.

This paper describes the methodological approach that the Patient Safety Group (PSG) will adopt to gather evidence of potential patient harm and to identify improvement actions to ensure the future safety of patients using PTS. A three-phased approach is described and the implications for resources are considered. The Incident Coordination Group is asked to:

1. Formally agree this method and approach to gathering evidence of harm, identifying areas for improvement and therefore ensuring that future patient safety can be assured;

2. Authorise the PSG to proceed with delivery of the plan with immediate effect.

1. BACKGROUND / CONTEXT

On 01/04/16 the Sussex patient transport service (PTS) was transferred from South East Coast Ambulance (SECAmb) to Coperforma Ltd, the new managed service provider. From the start of the new contract, significant issues and concerns were raised by patients, carers, families and NHS healthcare providers, that patient transport was arriving late or not at all for healthcare appointments, and discharges.

On 04/04/16 a level 3* Serious Incident (SI) was raised by High Weald Lewes Havens CCG Quality Team, on behalf of the 7 Clinical Commissioning Groups (CCG's) across Sussex and TIAA were commissioned, to undertake an independent external enquiry into the robustness of the procurement, transition and mobilisation of the PTS contract from SECAmb to Coperforma Ltd.

A Clinical Review analysing and categorising incidents raised by hospital trusts regarding PTS was also completed by the Senior Quality and Patient Safety Manager in July 2016, and the work of the Patient Safety Group builds on this.

An Action Plan has been developed by the Group which outlines the need to capture patients experience, access units and services from where it is known that incidents were reported, in order to gather evidence of potential patient harm, and assure patient safety in the future. This paper describes the methodological approach proposed by the PSG in meeting the objectives defined below.

1. AIMS AND OBJECTIVES

The key three objectives identified by the PSG are as follows:

1.1 To gather evidence of potential harm to patients, as a result of failures within the PTS;
1.2 To identify, and make recommendations on areas where further service improvements are needed, to assure patient safety in the future;
1.3 To support the Investigation Group should further non-clinical investigation be required.

2. PROPOSED METHODOLOGY

It is proposed that the above objectives are achieved by utilising a three-phased approach, as follows:

- Phase One – Concentrates on gathering evidence of patient harm by looking in more detail at the patients highlighted in the Clinical Review as categorised as having moderate or severe harm, to understand if and to what extent harm has occurred. Other priority patient groups include:
    - Patients who had identified themselves through the media
    - Complainants
    - DNAs
    - Wider review

- Phase Two – Concentrates on analysing the data and evidence generated from Phase One and triangulating it with information gathered from other sources to identify if further information is required from either the patient via a structured questionnaire and or site visits to obtain a complete representation of the experience of affected patients

- Phase Three – is the delivery of an evidence-based written report, highlighting the key findings based on the evidence-based methodological approach adopted, and will conclude with recommendations.

A comprehensive Action Plan has been developed by the Patient Safety Group[3] which details the key actions required to meet the objectives as defined above. The Action Plan focuses initially on the delivery of Phase One, Phase Two will be expanded within the PSG Action Plan, as the work of Phase One is completed and reviewed.

The three phases are described in more detail as follows:

2.1 Phase One

The Senior Clinical Quality Manager at HWLH CCG conducted a Clinical Safety Review looking at incidents logged on hospital incident reporting systems from 1st April to mid-June. Circa 900 incidents were logged during this time period by most of the Sussex hospital providers, although this number is likely to be lower than the actual number, due to under-reporting, as described in the review paper. Using the grading criteria in the clinical review, the incidents were graded as no, low, moderate or severe harm. The findings of this report established 190 patients in the last 2 categories with 187 classified as moderate and 3 as severe harm. It should be noted however, that although this grading on a recognised criteria, the review is subjective and may over or underestimate the level of harm. It is felt that this risk has been mitigated due to the criteria used.

The PSG will examine this cohort of patients to gain a more detailed understanding of the impact of the failings in the patient transport service on the individual patients, using the following process:

1. Write to the providers asking for patient identifiable data relating to each incident recorded (required as the CCG is not a data controller / able to hold patient records). This data will be held following Caldicott Guidance and Data protection Legislation.
2. The information will then be passed to Coperforma Ltd for them to process, identify and share what has been recorded on their Dynamic Planning System relating to the individuals journey.
3. The PSG will then triangulate the 2 sets of information from the incident reporting system and Coperforma Ltd systems to identify what has happened, where harm has been caused and the reasons.
4. Individual meetings may take place with these patients if needed, to conduct a structured questionnaire in order to gather more information and a richer picture
5. This process will then be followed for using a sample of patients who have formally complained about their transport experience.

[3] Action Plan, PSG, subject to ratification by ICG on 23/8/16

2.2 Phase Two

Phase Two is the comprehensive data analysis and evaluation phase, where all the key findings of the information collected in Phase One will be reviewed by the PSG. Data from interviews will be reviewed using a thematic analysis approach, identifying key themes and cross-referencing this with other data. The key findings will inform the PSG of areas where service improvements may be necessary in order to ensure patient safety in the future.

Site visits will be organised if it is felt more information is needed. Initial contact to the unit will be made by Dr Sarah Richards and the purpose of the PSG team's visit will be explained. In order to support data collection, a semi structured questionnaire will be developed.

Once the site visit has been completed, the PSG will review the methodical approach used, and based on experience make amendments to the model as deemed necessary. This is to ensure that continuous improvement in our working methodology is made accordingly.

The process will be then repeated for the other sites as necessary.

DNA information is also to be considered. Initial work has already begun by the Assistant Director of Delivery at ESHT and will be continued first. Consideration of extending to other Providers will be considered after this.

The PSG will ensure that – in the event of any harm being identified to patients at any point during either Phase One or Two - appropriate follow–up will be arranged, directed to the relevant service provider as necessary.

2.3 Phase Three

The final Phase includes the preparation and delivery of a comprehensive written report, which will detail the key findings based on the evidence-based methodological approach adopted, and will conclude with recommendations. Recommendations may be made aimed at local level, regional level, or wider NHS level as appropriate.

3. ACTION PLAN

A comprehensive Action Plan has been developed to reflect the overall work of the PSG, including the detailed actions relating to this specific element – i.e. the identification of potential patient harm and assurance of patient safety going forward. The action plan will be refreshed and amended with any further actions that are identified through this process.

4. RESOURCE IMPLICATIONS

The requirement for resources to support Phase One and Two have been considered and can proceed straight away as resources are already in place and commissioned by the CCG. The rationale for this is that patients visiting the Renal Unit are regular attenders, are a well-defined cohort and gathering of data as described is perceived as being unproblematic at this stage. However, it is possible that further resources may be required for subsequent site visits as they are significantly different (more dispersed) cohort of patients. As previously mentioned, there will be a post site visit review of the process, and it is anticipated that this will inform the PSG of potential resource requirements for second and subsequent site visits.

5. SUMMARY

This paper has proposed the approach and a methodology to meeting the objectives, as defined in Section Two. It describes a three-phased approach of data collection, analysis and site visits to establish key findings, and final report-writing. Clear recommendations will be made for local, regional and national level, as applicable.

6. RECOMMENDATION

This paper will be re-presented to the Incident Co-Ordination Group on Tuesday 30th August.

The ICG are requested to consider the key points within this paper and the approach being proposed by the PSG, and is asked to approve the model as described therein.

It is further recommended that – subject to ICG approval – the work of the PSG in executing this plan should be implemented with immediate effect, in order to maintain pace in progress to meeting the objectives identified herein.