FOR HEALTHCARE LEADERS

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MOVING UP A GEAR

WHY PATIENTS ARE FINALLY GETTING A SMOOTHER RIDE

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Alison Moore

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The job of getting people to hospital and back has been bedevilled by a host of seemingly insurmountable problems, but Coperforma is now helping trusts get to grips with the flaws in their systems, as Alison Moore reports.
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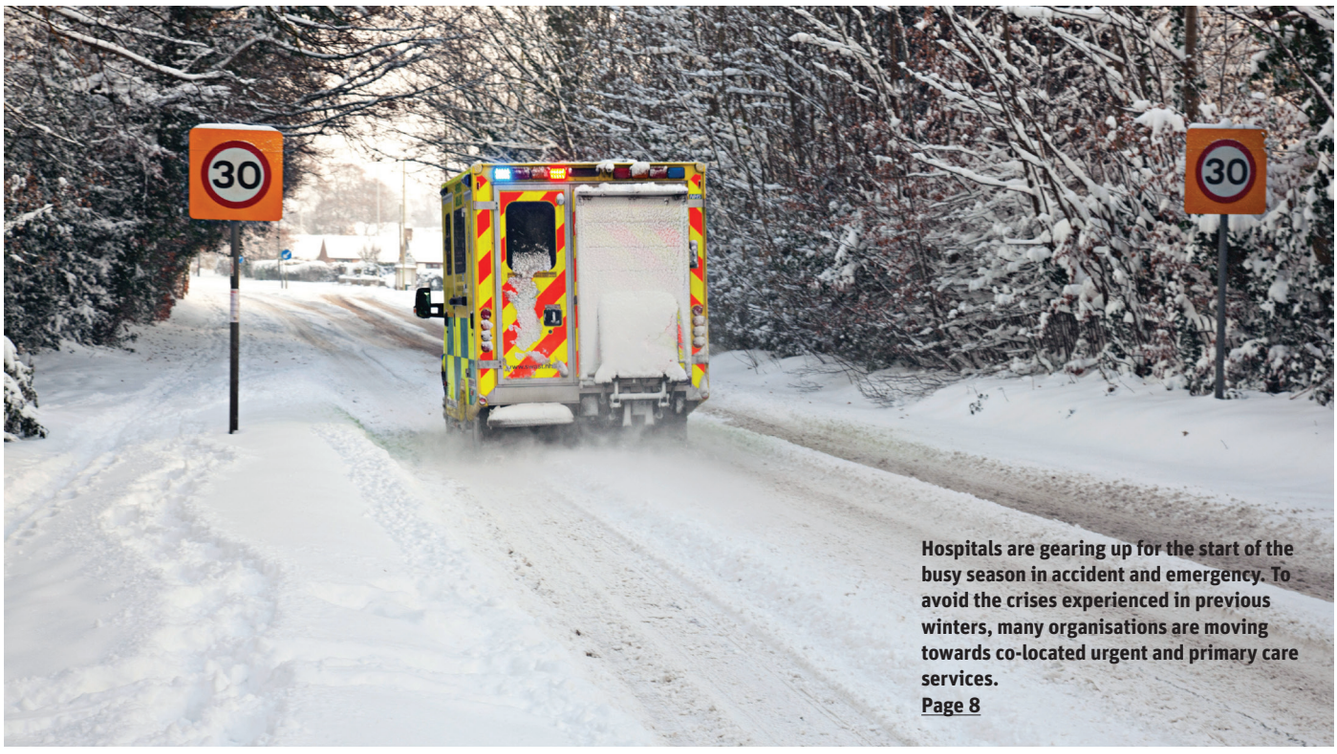

Hospitals are gearing up for the start of the busy season in accident and emergency. To avoid the crises experienced in previous winters, many organisations are moving towards co-located urgent and primary care services.
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MICHAEL CLAYTON
TRANSPORT ON THE MOVE

IN ASSOCIATION WITH COPERFORMA

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The NHS has traditionally struggled to provide efficient patient transport services simply because it uses a rigid system to manage a fluid process: transport that is booked in advance simply can't adapt to the changing landscape of a typical hospital day.

But Coperforma can. We have developed our own live scheduling system that can respond in real time to fluctuating transport requirements. We can tailor the service around the patients so they arrive in time for their appointments and leave when they are ready to go.

Our software also allows us to tailor the service for a particular clinic or ward by defining a set of "rules" for their pick-up and arrival time margins and the physical or medical needs. These rules are then embedded into the scheduling software to make sure we send the right kind of vehicle with the right equipment on board at the right time and with an appropriately skilled crew.

We also use our software to ensure we are making the best possible use of the available resources. We do this by simulating the current transport patterns then using temporal and geographic demand flattening techniques to relieve the pressure points. For example, we have discovered that by managing appointment times carefully, the inbound vehicles would arrive just as the previous wave of patients is ready to leave. Or that over 20 per cent of

'Undercover patient champions report back on transport experiences'

patients are travelling much further than needed for treatment because the local reconfiguration of services has created overlooked opportunities for transport efficiency.

No matter how satisfied our customers are with our transport services, our company philosophy dictates that there is "always room for improvement". So if there has been a problem with some aspect of a patient's journey we make it our mission to investigate and solve the root cause.

We use undercover "patient champions" to report back on their daily transport experiences. We solicit feedback through patient transport focus group meetings. And our on-site service delivery teams carry out satisfaction surveys every day with patients and clinical staff. This continuous quality improvement process strips the errors and waste out of the hospital's patient transport service.

And as the quality goes up, the costs come tumbling down. In fact, our model is proven to save NHS customers up to 25 per cent of their previous spend on transport and raise service satisfaction levels by at least 40 per cent.

Michael Clayton is managing director of Coperforma.

PATIENT TRANSPORT

DROP-OFFS DESERVE A PICK-ME-UP

Patient transport services are notoriously erratic, exacting a heavy toll on patients and trusts. So does it really have to be like this, asks Alison Moore

Getting non-emergency patients to and from hospital has probably never been the top priority for many trust boards – but that does not stop it being a headache.

While a patient transport service is typically only around 1 per cent of hospital budgets, they can be a major source of complaints and practical problems such as patients not arriving for appointments on time or being discharged unexpectedly.

The traditional way of running such services – having pick-up times which are fixed well in advance – can often lead to patients facing long delays for transport home or missing the scheduled car or ambulance as their appointments overrun.

A survey looking at patient transport services in Yorkshire showed that response times were by far the most common reason for complaints, generating more than half the complaints about the ambulance service. And a report to Yorkshire Ambulance Service's board earlier this year said that some patients were arriving more than 90 minutes before their appointment time or an hour late.

In many areas, these services are being put out to tender, in some cases moving from ambulance services to private transport companies as a result. But no matter who provides the staffing and vehicles, the problem of scheduling is likely to remain. Poor scheduling can mean knock-on costs – from booked transport which is not used but still has to be paid for to staff waiting for patients to arrive and clinics running late.

Is there a cure? One way is to use a system which is more responsive to the patient and takes into account how long it actually takes them to get through the hospital system. This can allow transport to be deployed as needed rather than being sent at a time which someone has guessed will be right for the patient.

Michael Clayton, managing director of Coperforma, which provides a range of patient transport services, has no doubt that patient transport is an issue hospital managers do not want to have to spend unnecessary time on. They simply want a service which runs smoothly and they do not have to think about.

While the number of patients entitled to such transport may be low as a percentage of the patients who use a hospital, typically they will be frequent users of hospital services, many obviously have severe health problems and are more likely to be from deprived areas.

Unexpected questions

His company is often asked to do an efficiency review of existing services, which identifies what performance is like within an organisation. "Quite often the information we flag up to the board comes as a complete shock," he says. "They know it is bad but not that bad. One trust which we analysed had only six per cent of patients being picked up on time."

Boards may have seen lots of complaints about patient transport but may have viewed them as individual problems rather than a sign the system was not working as it should. But such reviews often throw up unexpected questions. If the patient transport system is struggling to cope with a large number of patients arriving at the same time, does it say something about how the staff at the hospital are coping as well – and could a redesign improve services for patients?

Sometimes there are uncomfortable answers for trusts. One trust had a contract

CASE STUDIES OVERLEAF ▶

ALAMY

which seemed good value, but was performing badly in terms of patient experience. To improve that, the trust might have to invest more in transport. Others were paying a reasonable amount but were getting a relatively poor service.

In some cases, Coperforma is asked to provide a scheduling service, sitting between the trust and whichever organisation holds the transport contract. In others it takes on the patient transport services contract, providing transport for patients who don't need in-journey care (often sub-contracted to ensure a variety of vehicles are available) and running the scheduling system.

Mr Clayton says that traditionally transport arrangements are booked 24 hours in advance.

'Quite often the information we flag up to the board comes as a complete shock'

"They are really planning to fail because things have changed by the time they get to it," he says. When Coperforma has analysed booked activity and when patients actually need transport, 87 per cent of timing had changed.

This can be because the patient no longer needs the inward journey to hospital, or because they will be ready to return home at a different time from expected.

"When you combine a patient's condition – which is changing quite often – with a busy hospital with delays caused by late-running clinics, prescriptions not being in place and so on you get a situation which is very fluid," he says.

The solution he advocates is to have a dynamic booking service which allows clinical staff – the ones dealing with the patient – to indicate when they will be ready to return home. This can be done on a computer with the clinician clicking to show that a patient is ready to return home and that transport can be scheduled. And patients who are being taken to hospital are contacted before the trip to ensure they are still able to travel in the planned vehicle.

A hard look

But at the same time PTS providers need to work closely with hospitals to spot problem areas and to get a feel for how many patients are likely to be discharged and need transport on any given day. Transport availability can be important in ensuring discharges are done as soon as possible – freeing up beds for emergency admissions.

But why should trusts have a hard look at their patient transport services? One reason is financial. A large trust may be spending £5m a year on patient transport costs: many providers of PTS will charge if transport is ordered but then not needed, so there is potentially significant waste, as well as the impact on other areas of the trust if appointments are missed or discharges are delayed.

Mr Clayton says his clients can make savings on their patient transport services costs of up to 25 per cent: while Coperforma does take a cut of any savings, it also funds the cost of the software system and associated staff, so there is nothing for the trust to pay upfront.

"I think it shows that we put our money where our mouth is," he says. The firm only makes money "if we make the savings and keep the quality levels to the parameters the trust has set".

But the real benefit is in a higher quality service for patients, who are often elderly or disabled and don't want to have long waits to get home after treatment or appointments. "If we keep the quality up, the cost savings will follow. When quality is driven upwards we have demonstrated that the costs just fall away," he says. ●

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PATIENT TRANSPORT: CASE STUDIES

DRIVING CHANGE FORWARD

An overhaul by Coperforma tackled the difficulties experienced by patients from The Royal London Hospital and Hampshire Hospitals Trust, as Alison Moore explains

BARTS HEALTH

Renal patients are heavy users of hospital transport services, often needing to come into hospital several times a week from some distance away.

Yet many NHS organisations will be familiar with a situation in which these patients are picked up early in the morning, may have a long journey as other patients join the same vehicle, arrive late for appointments and then have to wait for transport home. All of this on top of hours on a dialysis machine can lead to long days and a less than fantastic patient experience.

That was the position which some renal patients at the Royal London Hospital – part of Barts Health – used to be in. At the extremes, patients reported being dropped off three hours before appointments and others had been taken home four hours after their treatment had ended. Many were travelling further than they needed and spending a lot of time on the journey.

And from a trust point of view late arrivals led to problems in the renal department and affected clinics. Patients who arrived late might have to be rebooked.

But that is changing. Trevor Payne, who took over as director of estates and facilities at the end of last year, says renal patients were making up a major part of the trust's PTS requirements and he felt the service could be improved for them. Key areas he wanted to address were ensuring eligibility criteria were standardised, but also looking at bookings and the logistics of picking up and dropping off people on time, without undue waits and within the resources available.

Reducing time on the vehicle was part of this: patients at the start of "pick-up" routes were often the last to be dropped off, and could spend several hours on the vehicle, frequently feeling concerned they would miss their appointment. He wanted to offer them something more in line with modern expectations of "the sort of service we all expect from people like Amazon and Google. That was really a driver for what we were doing. The difficult bit should be the treatment – not the journey".

The trust decided to make major changes, bringing in Coperforma to analyse the service and then to make changes, under a service-level agreement. Coperforma were committed to significant improvements – including an 8 per cent cost saving in the first year, patients arriving between five and 45 minutes before their appointment and being picked up within 30 minutes of the appointment ending, and eliminating complaints.

Coperforma put in a software system which would revolutionise the way transport worked but also to analyse what was happening to patients and why.

Mystery shoppers

Insight from this exercise was then used to make changes to the system to improve patients' experience but also help the trust. For example, the analysis showed that 24 per cent of patients were not going to the nearest renal centre. "Swapping" some patients between centres has reduced this and meant many patients had shorter journeys.

"We needed to be mindful of where people live and also that some people like travelling together – they are travelling on the same days each week. The system we have put in allowed for that," explains Mr Payne.

Another innovation has been to set up a patient group to give feedback on the service and effectively act as "mystery shoppers".

The patient transport service at the trust is provided by several organisations – reflecting its relatively recent merger – and initially there were some concerns. Staff had been used to one way of working and were hesitant about changing – there was a need to change "hearts and minds," he says. Drivers were given PDAs which they would use to book in and sign off on a job – ensuring it was obvious who was available for a pick-up and who was busy.

In the longer run Mr Payne suggests technology could drive other improvements – possibly apps allowing patients themselves to say when they are ready to go home, for example.

The changes in the renal transport were intended as a pilot project. "We thought if we could crack it in renal then it would work anywhere else in Barts Health," says Mr Payne. However, the improvements since March show the percentage of patients arriving on time has risen from 39 per cent to 96 per cent and those leaving on time from 6 per cent to 93 per cent.

The plan now is to roll out similar changes across the trust at all sites. These changes should be in place by February 2014 – a year after the original pilot got off the ground.

And as well as an improved service for patients the trust has been able to identify

A patient is transported by ambulance for a hospital appointment in Yorkshire

potential savings from the changes across the trust, expected to be £1.4m in a full year. The pilot has also helped it understand where patients are coming from and has opened the possibility of service changes to serve patients better.

"It is completely replicable across the NHS. Nothing we have done could not be done elsewhere," he says.

'The Barts system is completely replicable across the NHS. Nothing we have done could not be done elsewhere'

HAMPSHIRE HOSPITALS

Timeliness and reliability are the key factors for patients using transport services – but they are also important for hospitals.

If patients arrive late for clinics it can have knock-on effects on the whole hospital, with outpatient clinics forced to run late, potentially affecting consultants' other commitments later in the day.

But a poor experience with patient transport can also colour their opinion of the whole hospital visit – and as patient choice becomes more important that can ultimately affect reputation and lead to lost income.

So it is not surprising that Hampshire Hospitals Trust – which runs services in Basingstoke, Andover and Winchester – is keen to ensure patients get a good experience from start to finish. With nearly 1,000 patient journeys a week across its hospitals, that is quite a challenge.

Operational services manager for unscheduled care Sara Sparks says the trust works closely with Coperforma, which provides its patient transport services for non-urgent cases.

Weekly meetings aim to identify any problems and resolve them, while monthly meetings take an overview of the performance. Staff from different departments are now being invited to attend these meetings to talk about their experience and the actions being taken to resolve any issues. There is also close contact with the service delivery managers who are on site – whom Ms Sparks describes as "positive and reactive". But she adds that it is important the trust's staff are proactive and feed back any problems so they can be resolved.

The trust has recently invited Coperforma to get involved in bed management meetings, which help the company plan for likely discharges – and ensure patient transport issues do not hold up discharges and prevent beds being available for other patients.

Coperforma and the trust have also worked together on staff training to ensure that they use the system effectively; bookings are increasingly being made online rather than by phone. Although Coperforma tries to be responsive to individual needs and timings, it helps to have information about patients who are likely to need transport in advance. So a particular focus has been reducing inappropriate on-the-day bookings by encouraging staff to plan ahead and alert it of transport needs in advance.

As a manager with responsibility for departments covering emergency care, Ms Sparks is conscious that timeliness is vital: with a four-hour target for care, having patients waiting several hours for transport home seemed out of kilter. The service-level agreement has now reduced the maximum time patients should have to wait to 45 minutes. And service levels can differ between clinical areas across the hospital to reflect priorities and circumstances.

The trust is the result of a recent merger. But Coperforma has been running non-emergency services at the Basingstoke and North Hampshire Hospitals – one of the two former trusts – for three years. In that time it has reduced costs by 29 per cent and improved satisfaction levels to 95 per cent (before it took over 48 per cent of journeys were evaluated as unsatisfactory), it says.

Improved booking systems have brought down the number of cancelled or abandoned journeys, and have led to the use of more appropriate vehicles – often smaller ones. This has reduced associated carbon emissions by 40 per cent. ●

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JIM CHASE
SMART TRIAGE IS THE ANSWER

However much NHS managers want to steer non-critical patient care away from accident and emergency, they may be fighting a losing battle against patient choice. A pragmatic alternative is to manage patients more effectively once they've walked through the door.

Patient choice is becoming as much of a driver for healthcare initiatives as government targets and budget challenges. In hospital A&E departments this is increasingly the case. Even with the raft of admission avoidance schemes designed to alleviate the pressure on these critical health services, the volume of patients who present themselves continues to rise.

Despite access to services like NHS Direct, NHS 111 and out of hours GPs, some patients are voting with their feet and choosing to queue for appointment-free consultations at their nearest hospital.

Given that existing attempts to intercept and divert non-urgent cases to alternative services have failed to stem the flow of patients presenting at A&E, trusts need to adopt new strategies to keep emergency services clear so that they can devote their resources to life-threatening cases. Failure to manage rising patient numbers means high risk to patients who really need urgent attention; it is also highly inefficient and costly.

The answer, as a number of trusts have now realised, is to develop more effective triage facilities, where presenting patients can be intercepted and channelled towards appropriate services within the hospital's premises. At trusts where this strategy has already evolved, there have been associated efforts to make primary care provision on site, in the form of co-located "urgent care centres", staffed by GPs and nurses. Having primary care clinicians on site who can handle non-life threatening cases is a pragmatic solution for hospitals that still find themselves with severe A&E bottlenecks.

The challenge then is to manage the triage process. It is here that technology comes in. Where patients are directed away from urgent care towards a nurse and then GP, it is important that relevant case and patient histories can be accessed in the consultation so that decisions are fully informed.

For now, on-site urgent care centres are still at the trailblazing stage. Adopting this model requires vision and joined-up thinking. But it is an effective solution to a problem that won't go away. In time, as trusts realise they cannot stop patients from turning up at A&E with a whole range of conditions, co-located emergency/primary care services will become more common. Providing an on-premise primary care alternative is cheaper and quicker than allocating A&E resources indiscriminately, and it ringfences frontline emergency care for those who really need it.

Jim Chase is managing director of Advanced Health & Care. **www.advancedcomputersoftware.com/ahc**

WINTER PRESSURES

LET IT FLOW, LET IT FLOW, LET IT FLOW

As trusts begin to prepare for accident and emergency departments' busy season, a concerted move towards co-located urgent and primary care services to take the pressure off is gathering pace, writes Alison Moore

As we move towards the autumn, many trusts will be focusing on how to ensure their accident and emergency services meet performance targets and cope with the winter rush.

But doing that will require the involvement of other parts of the NHS to ensure patients with more minor illnesses and injuries are treated in the most appropriate setting, leaving A&E to concentrate on the seriously unwell or injured.

In May, the College of Emergency Medicine suggested that co-located primary care services could take between 15 and 30 per cent of the A&E workload but that service integration was vital.

And during the summer, the Commons health select committee called for co-located urgent care centres to be considered where they do not already exist – but it also warned of the need to communicate what they could and could not do.

Jim Chase, managing director of Advanced Health & Care, says that the trend towards alternative easily available primary care services started several years ago, with walk-in clinics. More recently interest has focused on co-located services which can take some of the strain off A&E.

These changes play into the debate about how to manage the increased demand that results from a desire to make access to care easier, he adds. "Perhaps we the public have changed? It could be that we are presenting where and when we want to present rather than how the NHS wants us to present," he says.

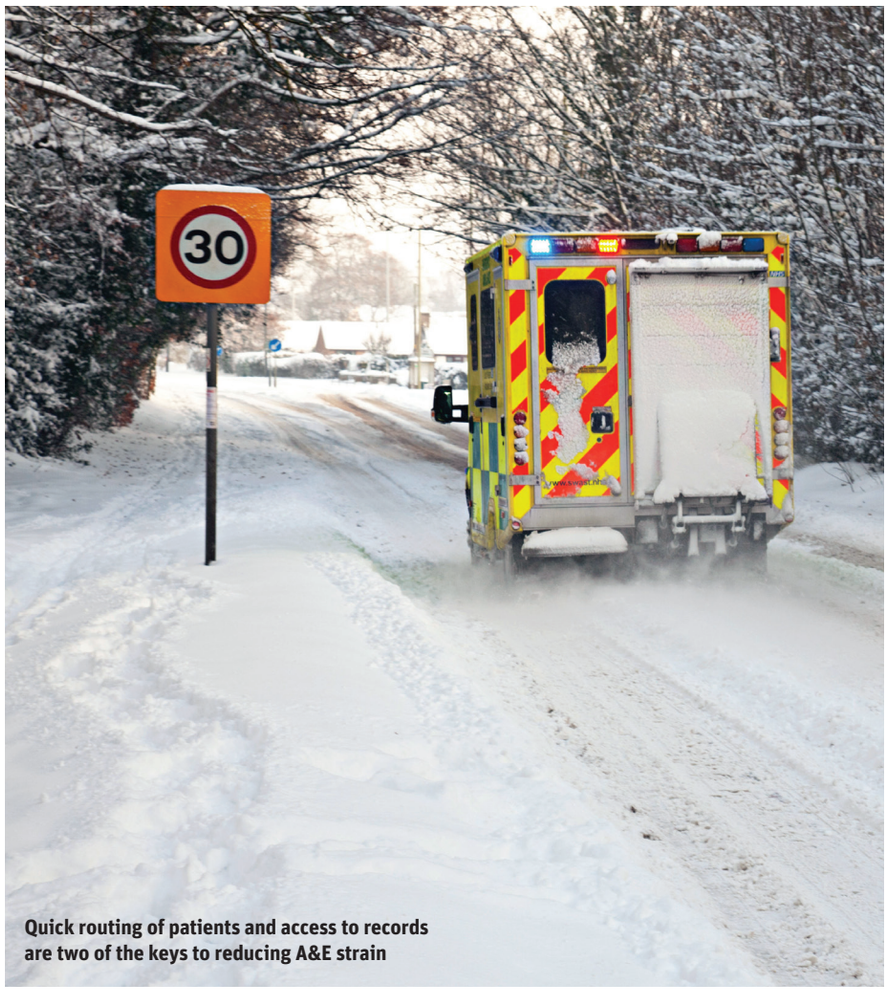
If this is the case, the NHS may have to respond to this by providing appropriate care where people present – and a number of his customers have already started to do this by putting primary care-led services alongside A&E.

The experience of these has been encouraging, suggesting a significant proportion of patients can be seen and treated in a primary care setting. For example, in Blackpool the primary care unscheduled care service is run by Fylde Coast Medical Services and paid for under a block contract by the CCG. It takes between 18 and 20 per cent of the patients who present, which significantly reduces the burden on the A&E department.

In Medway around 25 per cent of people who present at A&E are diverted into a primary care-led service which also provides a rapid response team for people discharged from A&E or the acute medical unit. Many patients who come into these services will also be treated more quickly than if they were in A&E – they won't be bumped down the waiting list if an urgent trauma case comes in, for example. And, by seeing an experienced primary care professional, they may have fewer tests than if they entered a full-blown A&E and be less likely to be admitted while tests are run.

But those who run these units stress that information flow is important, not just between A&E and co-located services – which assists the easy movement of patients between the two, if necessary, and limits the number of times patients have to give their details – but also out into other primary care and community services.

NHS medical director Sir Bruce Keogh's review of urgent and emergency care made this clear, stressing information critical to a patient's care should be available to all those treating them.



Quick routing of patients and access to records are two of the keys to reducing A&E strain

Mr Chase says: "You need safe, quick prioritisation and routing of patients, access to patient records such as the summary care record, auditability and safe onward referral and messaging to GP patient records. Add the ability to pass cases to and from A&E systems and you have the basis of IT pre-requisites for urgent care centres. The benefit to the NHS is a quicker, cheaper and more appropriate consultation that is joined up with the wider NHS."

'The ability to share information and pass it between different providers helps us achieve excellent clinical results'

Excellent results

David Archer, director of service and IM&T at London Central and West Unscheduled Care Collaborative – which runs several urgent care centres, as well as GP out of hours services and two NHS 111 services – says access to key information can prevent inappropriate hospital admissions.

Suzy Layton, chief executive of Fylde Coast Medical Services, says this information transfer helps continuity of care. "Wherever a patient appears in our unscheduled care systems this makes sure that we have their unscheduled care record in front of us," she says.

Systems which work best tend to be ones which are driven by clinical needs and ways of working, rather than by staff having to change working practices to suit the IT system. Mr Archer says this is one of the advantages of the system his organisation uses – Adastra, produced by Advanced Health & Care.

"The operational model drives the IT solution rather than the other way round," he says. "And the ability to share information and pass it between different providers helps us achieve excellent clinical results."

Co-located services and better information flow will not solve all of the NHS's problems this winter but they could help A&E departments cope with increased demand. ●

THE STREAM TEAM: MEDWAY'S ON CALL CARE

Streaming patients so that those who can be are treated safely and appropriately by a community healthcare team is key to supporting Medway Foundation Trust's A&E service.

Around 25 per cent of the patients turning up at A&E are diverted to the Medway On Call Care (MedOCC) service after being triaged by a senior acute trust nurse.

Such patients are flagged up in the A&E department's computer system and their information is shared with MedOCC – although at times of pressure the GP and nurse-led service will proactively seek out other minor cases which it can treat safely.

MedOCC works with the rapid response team, which supports both A&E and the acute medical unit in getting patients home or into a community rehabilitation bed rather than admitting them unnecessarily. Another MCH community navigation team supports early discharge from the acute sector.

The glue binding these services together is shared information. Rob Howard, assistant director for business intelligence and IT at Medway Community Healthcare, the social enterprise which runs MedOCC and the rapid response team, says: "It is vital."

The Adastra and Advanced Community systems used allows for electronic referral between the services, he says, which saves staff time in phone calls. And it will allow them to communicate with different systems so, for example, electronic discharge notifications will soon be sent to GPs.

Many of the community nurses are already using tablet computers to access information close to the patient – so, for example, the rapid response team can find out whether a patient is already known to community health services and may have a care package in place. Mr Howard says it was the way Adastra was already used in mobile devices for out of hours services which influenced the organisation to choose it for the rest of its community services.

And operations director Oena Windibank says: "Our staff have been involved in choosing the right device for them: giving them technology they can easily use and value and so making their lives easier."

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