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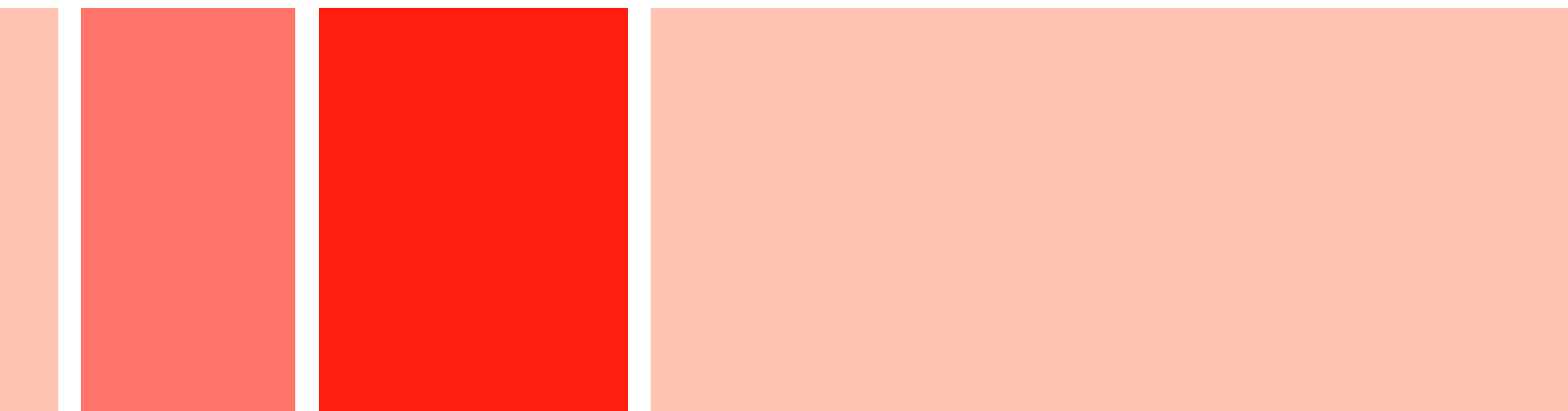
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Evaluation of the non-emergency patient transport pilots



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Based on research conducted by STC Ltd.

Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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Executive Summary

1 Non-emergency transport enables patients to access outpatient, day treatment, and other services at NHS hospitals, by providing transport to and/or from their place of treatment. Around 1.4 million such journeys are undertaken in Wales every year. Users of the service are often seriously ill, such as those needing dialysis or chemotherapy. They are frequently vulnerable, with physical or other disabilities, and are dependent on the transport, particularly if they live in rural locations.

2 In November 2007, the Minister for Health and Social Services commissioned a review of non-emergency transport services in Wales. The findings of this review, led by Win Griffiths, concluded that the existing system was fragmented and not geared towards the needs of the patient. The review recommended that a higher quality of service was needed in order to provide an improved patient experience.

3. In response to the findings of the Griffiths' Review, four three-year pilot projects were proposed in order to trial innovative models for delivering non-emergency patient transport services. These were:

Table 1: Pilot Objectives

	Description	Objectives
Betsi Cadwaladr	A control room improvement model Pilot site for the control room element of WAST's revised PCS model, operated under the existing partnership arrangements with BCUHB	<ul style="list-style-type: none"> - To introduce online booking to support the application of eligibility criteria in secondary care - To improve the discharge pathway from being admitted to leaving hospital - To reduce aborted journeys and reduce waste - To implement a control room performance management framework
Cardiff & Vale	Third sector partnership approach to deliver patient-centred transport An enhanced rapid discharge service in partnership with St. John Cymru	<ul style="list-style-type: none"> - To establish a flexible and responsive discharge service, with the aim of reducing delayed transfer of care - To improve overall patient experience
Cwm Taf	An integrated transport booking service	<ul style="list-style-type: none"> - To integrate IT systems between regional booking centre and WAST - To reduce the amount of double entry, potential for error, and improve data handling - To ensure eligibility criteria for transport are consistently applied

Hywel Dda	A model of integrated transport provision between LHB, local government, WAST, and the third sector	<ul style="list-style-type: none"> - To secure efficiencies through the integration and coordination of transport service provision - To maximise the use of existing transport resources - To provide a robust/whole system procedure for patients that need/qualify for transport assistance and improve the quality of service
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4. This interim evaluation was designed to assess the progress made by each of the pilots in developing an improved model of service delivery. This was achieved by:

- examining the degree to which the individual projects met their pilot-specific objectives; and
- identifying, where appropriate, to what extent the pilots addressed the issues highlighted by the Griffiths' Review.

5. Between October 2011 and February 2012, researchers from STC Ltd. conducted desk and field research to examine the operation and delivery of the pilot projects. Progress towards objectives was assessed using a mix of performance monitoring data provided by the pilots to the National Programme Board, as well as consultation with stakeholders and key users.

Findings

6. Notable progress has been made by the pilots in delivering improved services, particularly in terms of process improvements and collaboration in and across the pilot areas. At this early point in time, these process improvements constitute the main bulk of evidence to suggest that improved service models are developing. In addition, the pilots have shown some measure of success in addressing the Wales-wide issues with non-emergency patient transport that were highlighted by the Griffiths' Review. Future work will be better placed to evaluate the impact of the pilots on patient outcomes.

7. The establishment of performance indicators and the regular monitoring of data collection has been a key achievement of the pilot projects, particularly considering the low baseline of data availability from which the pilots began. The

National Programme Board has played a significant role in ensuring performance indicators were established and regularly reported.

8. The National Programme Board has also facilitated dialogue between health, local authority, and voluntary sectors, enabling a joined-up approach to delivery. Through regular meetings and workshops it has served as a vital forum to enable the dissemination of learning among stakeholders and the sharing of best practice.

Recommendations

9. All four pilots have demonstrated progress towards achieving their pilot-specific objectives and to addressing the issues with non-emergency patient transport identified by the Griffiths Review. Future work will be better placed to evaluate the impact of the pilots i.e. whether improved service models are delivering better outcomes for patients. It is recommended that an evaluation framework for the summative evaluation be developed as soon as possible so that there is sufficient time to gather relevant data.

10. Moving forward the pilots would benefit from the establishment of high-level performance indicators to allow for comparisons across health boards. However, these indicators should be collected in such a way that does not preclude disaggregation, in order to also allow comparisons within health boards. Indicators should capture both qualitative and quantitative measures, and record relevant pilot activity for all providers (i.e. not just WAST).

11. In order to better assess value for money there should be a strong focus on the development and collection of consistent and comparable financial indicators as the pilots move forward.

12. The NPB plays a vital role in the coordination and monitoring of the pilot projects, and it should continue its work in facilitating dialogue between stakeholders and identifying areas of promising practice which can be further investigated, understood and applied elsewhere. In addition, the NPB should continue to lead in the development of national and local performance indicators, with a view to establishing an evidence base that will enable future measurement of real improvements in the patient experience.

1 Introduction

Purpose

1.1 In November 2007, the Minister for Health and Social Services commissioned a review of non-emergency transport services in Wales. The findings of this review, led by Win Griffiths, concluded that the existing system was fragmented and not geared towards the needs of the patient. The review recommended that a higher quality of service was needed in order to provide an improved patient experience.

1.2 This report was commissioned to evaluate the four pilot models of non-emergency patient transport established in response to the findings of the Griffiths' Review. The main aim of this interim evaluation is to assess the progress made by each of the pilots in developing an improved model of service delivery. This was achieved by:

- examining the degree to which the individual projects have met their pilot-specific objectives; and
- identifying, where appropriate, to what extent the pilots have addressed the issues highlighted by the Griffiths' Review.

Evaluation approach and methodology

1.3 Between October 2011 and February 2012, researchers from STC Ltd. conducted desk and field research to examine the operation and delivery of the pilot projects. This report summarises STC's findings and uses them to address the objectives outlined above.

1.4 Background documents relating to non-emergency patient transport and subsequent pilot activity were reviewed for context. Progress towards objectives was measured using performance monitoring data from the following sources:

- Key Performance Indicators presented to the National Programme Board (NPB);
- Service Level Agreements (SLAs) between Welsh Ambulance Service Trust (WAST) and Local Health Boards (LHBs);
- performance monitoring data from Cleric;
- performance monitoring data from LHBs and other delivery partners; and
- public domain data, e.g. StatsWales etc.

1.5 Researchers also interviewed and engaged in consultation with a variety of stakeholders. Feedback was gathered from a range of service commissioners, service providers, and service users from across the four pilot areas. In addition, findings were also drawn from responses to existing patient surveys already operating in the pilot regions.

Structure of the report

1.6 The remainder of the report is structured as follows:

- **Section 2** presents the background for the establishment of the non-emergency patient transport pilots. It describes the context and findings of the Griffiths' Review, and provides an overview of the individual pilots and objectives.
- **Sections 3, 4, 5 & 6** evaluate the extent to which the four pilots have made progress towards meeting their own objectives, the objectives of the Griffith's Review, and delivering an improved service to patients.
- **Section 7** provides an evaluation summary. Recommendations for future action are also suggested.

2 Overview

Background

Non-emergency patient transport

2.1 Non-emergency transport enables patients to access outpatient, day treatment, and other services at NHS hospitals, by providing transport to and/or from their place of treatment. Around 1.4 million such journeys are undertaken in Wales every year. Users of the service are often seriously ill, such as those needing dialysis or chemotherapy. They are frequently vulnerable, with physical or other disabilities, and are dependent on the transport, particularly if they live in rural locations.

2.2 A first request for transport requires a patient to contact a Non-Emergency Transport (NET) centre, where staff will assess the patient against the eligibility criteria. Patients are considered eligible for transport services if they meet the criteria for medical need¹. For patients requiring non-emergency transport for discharge from hospital or for follow-up appointments, bookings are usually made by clinicians via their Ambulance Liaison Officers, or by liaison staff stationed at a WAST control centre.

2.3 Each health board has a Service Level Agreement with WAST to govern the provision of non-emergency patient transport services. Payment for non-emergency transport consists of three components:

- the majority is a block allocation based on historic trip rates and average costs per mile by vehicle type. A buffer of +/-5 per cent p.a. is included, i.e. patient journeys can increase or decrease by 5 per cent with no amendment in the overall payment to WAST;
- additional demand (or under utilisation) is calculated at a rate of 65 per cent of the average cost per patient journey;
- payment for extra contract referrals (ECR), which are additional journeys carried out by WAST on an ad hoc basis. WAST are reimbursed for these journeys individually.

¹As specified by the All Wales Protocol for Non-Emergency Patient Transport Eligibility Criteria.

2.4 Of the £5.2 billion per year spent by health boards on health care, approximately 0.42 per cent is used to fund non-emergency patient transport. While this accounts for a small proportion of total health expenditure, transport provision can have a significant impact on a variety of patient services, such as the timely conduct of clinics and the efficient flow of patients through a hospital.

The Griffiths' Review

2.5 The Griffiths' Review proposed four three-year pilot projects to trial different, more innovative models for delivering non-emergency patient transport services. The pilots were to be supported by the Welsh Government's 'Invest to Save' Fund and overseen by a National Programme Board.

2.6 The review also recommended that the pilots be evaluated after the first 12 months to establish whether improved service models were developing. In addition to assessing the progress made by the pilots in meeting their project-specific objectives, the evaluation was to also provide a broader assessment of all four pilots in terms of:

- assessing impact on the **timeliness and journey times** of non-emergency patient transport in the pilot areas;
- assessing how flexible approaches are in terms of **responsiveness to clinical requirements**;
- identifying any examples of **joined up working** with hospitals, e.g. joint planning of appointments;
- identifying **good practice approaches and assessing their transferability**;
- identifying any **barriers to success** and consider how they might be overcome;
- determining, as far as is practicable, which aspects of the pilot are best **value for money**;
- considering the extent to which opportunities **for integrated working** exist, are currently being exploited, and are realising benefits; and
- assessing the contribution of the **leadership** provided by the National Programme Board.

The pilots

2.7 The pilots were designed to trial four distinct models of service delivery. Each pilot focussed on improving a specific aspect of non-emergency patient transport, and thus each pilot had its own set of aims and objectives. A description of the pilots can be found in Table 1.

Table 1: Pilot Objectives

	Description	Objectives
Betsi Cadwaladr	A control room improvement model Pilot site for the control room element of WAST's revised PCS model, operated under the existing partnership arrangements with BCUHB	<ul style="list-style-type: none"> - To introduce online booking to support the application of eligibility criteria in secondary care - To improve the discharge pathway from being admitted to leaving hospital - To reduce aborted journeys and reduce waste - To implement a control room performance management framework
Cardiff & Vale	Third sector partnership approach to deliver patient-centred transport An enhanced rapid discharge service in partnership with St. John Cymru	<ul style="list-style-type: none"> - To establish a flexible and responsive discharge service, with the aim of reducing delayed transfer of care - To improve overall patient experience
Cwm Taf	An integrated transport booking service	<ul style="list-style-type: none"> - To integrate IT systems between regional booking centre and WAST - To reduce the amount of double entry, potential for error, and improve data handling - To ensure eligibility criteria for transport are consistently applied
Hywel Dda	A model of integrated transport provision between LHB, local government, WAST, and the third sector	<ul style="list-style-type: none"> - To secure efficiencies through the integration and coordination of transport service provision - To maximise the use of existing transport resources - To provide a robust/whole system procedure for patients that need/qualify for transport assistance and improve the quality of service

National Programme Board

2.8 The NPB was established in May 2010 to monitor the progress of the pilots. The Board meets bi-monthly, and members include representatives from the four pilot areas as well as WAST, third sector organisations, Public Health Wales, the Community Health Council, and Welsh Government. Each of the pilots is expected to report progress against an agreed set of Key Performance Indicators (KPIs) in advance of the meeting.

2.9 In addition to the bi-monthly board meetings, the NPB also runs monthly workshops for stakeholders to address specific topics and operational issues, including the inter-relationship between non-emergency patient transport and wider health service delivery. This is motivated by the recognition that non-emergency patient transport does not operate in isolation from other initiatives, and that a whole-systems approach is necessary to ensure the success of the pilots.

3 Betsi Cadwaladr

Background

3.1 Betsi Cadwaladr University Health Board (BCUHB) is the largest of the Health Boards in Wales, spanning the counties of Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham, and serving a population of around 676,000 people. BCUHB manages three district general hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and Wrexham Maelor Hospital), 22 acute and community hospitals, and a network of more than 90 health centres, clinics, community-health team locations and mental health units. The board also coordinates the activities of 121 GP practices

The pilot

3.2 BCUHB serves as the pilot site for WAST's trial of a new control room improvement model. This initiative is one component of a wider revised operating model put forward by WAST to provide a more citizen-focused approach to the provision of non-emergency patient transport. WAST operates the pilot within their existing working arrangements with BCUHB.

Objectives

3.3 The aim of the pilot is to develop an improved control room model for non-emergency patient transport. The objectives of the pilot are as follows:

- to introduce online booking to support the application of eligibility criteria in secondary care;
- to improve the discharge pathway, and consequently the patient pathway, from being admitted to leaving hospital;
- to reduce aborted journeys and reduce waste; and
- to manage these within a new performance management framework.

3.4 The following section presents the evidence gathered by STC Ltd. to assess progress towards the achievement of those objectives. The bulk of this evidence is drawn from the KPI indicators reported by the pilot to the NPB and interviews conducted with key users, such as clinicians and hospital staff. However, caution should be taken with the significance attached to interview data, as it is unclear from the presentation of the research findings the degree to which the views gathered relate to pilot activity.

Introduction of online booking

3.5 Previous research identified that requests for transport originating from secondary care facilities often did not take patients through the eligibility criteria for travel. The introduction of online booking at the ward/clinic level was intended to counter this, with users being prompted through the eligibility criteria when making the request.

3.6 There is evidence that use of the online booking process by staff has been increasing throughout the life of the pilot. According to monitoring reports provided to the NPB, data for October 2011 showed that 56 per cent of staff were utilising online services within BCUHB. By February 2012 this had increased to 85 per cent.

3.7 Where the eligibility criteria are concerned, improved application of them by hospital staff when booking transport should result in a reduction in the proportion of journeys made for patients classified as mobile and independent and, overall, better demand management. Table 2 shows the number and proportion of T1² patients using non-emergency patient transport from September to November 2011.

Table 2: BCUHB Number of T1 discharge patients transported

Description	SEP 2011	OCT 2011	NOV 2011
Number and proportion of discharge patients transported categorised as T1	585 (36%)	496 (34%)	494 (33%)

These activity data show that the percentage of patients classed as T1 has been decreasing since the introduction of online booking in October 2011. Figures from pre-September 2011 should help to determine if this small decrease is due to pilot activity or natural variability in the data. Continued monitoring of this KPI will provide means of assessing whether online booking leads to better application of the eligibility criteria, particularly as take-up of the online service among secondary care facilities will increase over time.

3.8 Staff feedback illustrates additional benefits that have accrued from the introduction of the online booking system. One member of staff estimated that online

² T1 patients are classified as those patients who can walk unaided or require minimal assistance

bookings had saved up to three hours a day of staff time, which was previously spent having to call, fax, or physically take transport bookings to WAST.

Improved discharge pathway

3.9 Graph 1 shows patient waiting times for discharge or transfer since the beginning of the pilot:

Graph 1: BCUHB: Percentage of discharge patients waiting <60, 60-90, 90-120 and more than 120 minutes, by month

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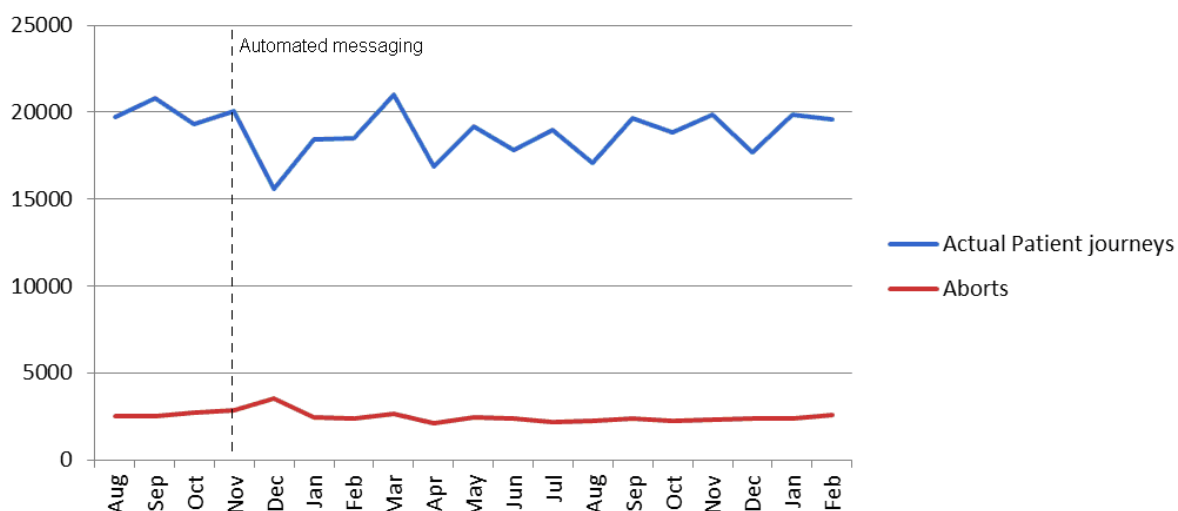
The proportion of patients waiting more than 120 minutes for discharge or transfer has significantly reduced over the life of the pilot. There has also been an overall increase in the proportion of patients waiting less than 60 minutes for discharge or transfer. This suggests an improved discharge pathway for patients is developing, with evidence of improved patient flow throughout BCUHB.

3.10 Additional activity unrelated to the pilot may have also impacted the timeliness of discharges and transfers. For example, in March 2011 a single point of contact for discharge was introduced which was easily accessible to WAST staff and improved liaison by removing the need for WAST to go to wards to collect patients. While it is not possible at this stage to determine the relative contribution of the pilot and single point of contact to delivering these improvements, the reduction in waiting times is an encouraging sign.

Reduction of aborted journeys

3.11 Data provided to the NPB show that the number of aborted journeys has remained relatively stable at between 10-12 per cent across the life of the pilot, with the exception of a peak in November and December 2010, relating to exceptionally poor weather conditions. This is roughly in line with the KPI performance target of 10 per cent.

Graph 2: BCUHB: Number of aborted and total journeys by month



3.12 Table 3 describes the reasons given for aborted journeys for a sample month.

Table 3: Reason for aborted journey, October 2011

Reason for aborted journey	% of aborted journeys
No appointment	20.33%
Too ill to travel	19.32%
Own transport	16.46%
No reply	7.24%
In hospital	5.76%
Wrong date of travel	3.46%
Late clinic	3.46%
Aborted by patient	2.54%
Aborted by hospital	2.21%
Admitted after treatment	2.31%
Not ready	2.07%

This information illuminates key ways in which the pilot may help to reduce the proportion of aborted journeys over time. For example, work to improve the application of eligibility criteria may reduce the overall number of patients with their own transport being initially approved for services, which could then lower the rate of

aborted journeys in this category. Again, monitoring changes in these indicators over time is a simple means of assessing the extent to which this happens.

3.13 The pilot has also generated innovative practices specifically directed at reducing the number of aborted journeys. Automated messaging was introduced in November 2011 as a method of reducing the number of journeys aborted due to a patient forgetting / not being ready for transport. The messaging service contacts patients by text or voice recording with a reminder of their transport booking, and provides a prompt to cancel if transport is no longer required. Early reports by WAST to the NPB indicate that this service is having a positive impact on reducing aborted journeys.

3.14 The most common reason given for an aborted journey was that the appointment for which the patient was being collected had been cancelled. This suggests a breakdown in communication channels between an appointment being cancelled and WAST being informed. Further investigation of this issue may provide a focus for future action to reduce the number of aborted journeys.

3.15 Table 3 also reveals that there are factors impacting the aborted journey rate which are likely to be unaffected by intervention by WAST or BCUHB, such as a patient being too ill to travel or being admitted after treatment rather than returning home. This implies that for BCUHB, as well as for the other pilot areas, there may well be a threshold point to which the aborted journey rate will not drop beneath³.

Introduction of a new performance management framework

3.16 WAST has introduced a new performance management framework for its PCS Control Centre, including the implementation of a dashboard which highlights specific KPIs onscreen to help manage and drive performance. The dashboard is designed to improve the understanding and use of KPIs by staff.

3.17 The new framework has also implemented a number of changes to working practices, such as team-based working and individual accountability for planned

³ Using the example of October 2011, 21 per cent of aborted journeys were due to unavoidable circumstances (patient too ill to travel / admitted after treatment). This represents 2 per cent of total journeys, and indicates that for October 2011 the aborted journey rate could not have dropped below 2 per cent.

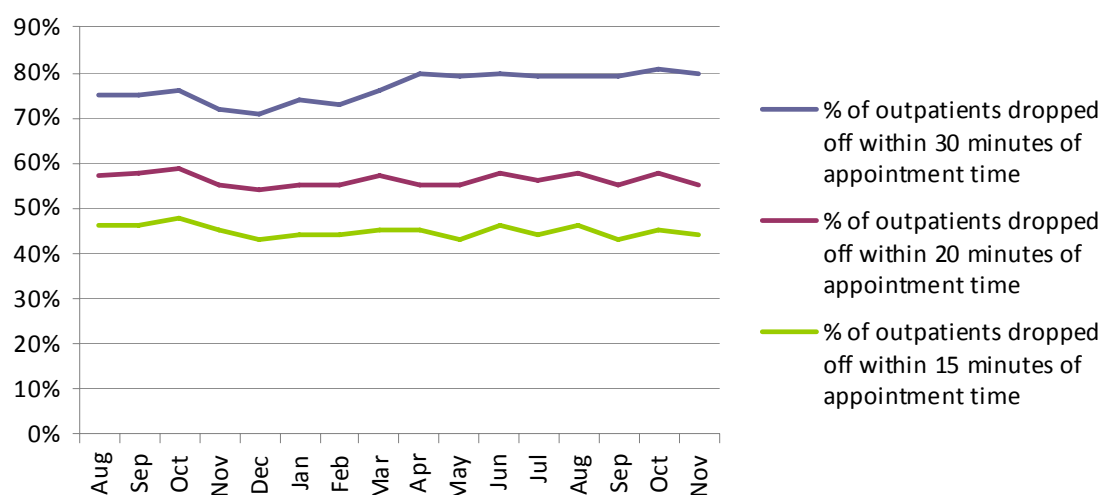
patient transport journeys. There are now also daily conference calls between staff to address specific patient issues and monitor performance. This environment is designed to encourage and facilitate the immediate escalation of issues that are impacting on the ability to deliver KPIs.

Evaluation against the Griffiths' criteria

Timeliness and journey times

3.18 Pilot activity was not expected to impact on factors affecting the timeliness of a patient's arrival. As shown in Graph 3, the timeliness of patient's arrival for outpatient appointments has remained relatively constant throughout the duration of the pilot, with a slight improvement in the proportion of patients dropped off within 30 minutes of their appointment time.

Graph 3: BCUHB: Percentage of patients dropped off within 15, 20, and 30 minutes of appointment times



3.19 In contrast, one of the objectives of the pilot was to improve the discharge pathway for patients from being admitted to leaving hospital. As discussed in section 3.9, there has been a significant reduction in the number of discharge and transfer patients waiting more than two hours for transport and a corresponding increase in patients waiting less than sixty minutes.

3.20 The pilot was not explicitly directed at reducing journey times, although improving the application of the eligibility criteria for transport was hoped to reduce the number of patients that needed transport, and thus reduce the number of drop-offs a vehicle would have to make per journey. Data are not currently available to

determine if this has occurred, but future monitoring of demand and patients-per-journey may provide useful information relating to journey times.

3.21 Available data show that the average time a patient spends on a vehicle has dropped from 45 minutes in September 2011 to 40 minutes in November 2011. However, this is not necessarily indicative of an overall downward trend, and could be influenced by a number of other factors unrelated to pilot activity.

Responsiveness to clinical and patient requirements

3.22 The new performance management framework has led to changes in working practices that allow increased responsiveness to both clinician and patient needs. The change in management frameworks has led to the revision of staff rosters, resulting in extended operating hours for the control centre, improving both patient and clinician access to PCS control. In addition, new practices, such as automated text messaging and the availability of online booking, have been designed to make PCS more engaged with and responsive to user needs.

Joined up working / integration

3.23 Improved collaboration between WAST and BCUHB was reported by all of those consulted in the region, including the health board management team representative, WAST non-emergency patient transport lead, Control Room managers, Ambulance Liaison officers, and clinical staff in the both the discharge lounge and oncology departments.

3.24 WAST has recently held discussions with Wrexham Borough Council on the possibility of piloting an integrated approach to the delivery of social care transport and non-emergency patient transport.

Good practice approaches

3.25 A number of innovative practices introduced through the pilot, such as online booking and automated text messaging, have helped to achieve an improved model of service delivery. There would seem to be merit in WAST considering the feasibility of introducing these practices into other health board regions.

3.26 Throughout the pilot, WAST kept a log of each new initiative, including documentation relating to how each activity was designed and implemented. This log has been used to support the roll out of initiatives piloted in one facility/location to another facility/location.

Barriers to success

3.27 STC's interview findings reported that WAST encountered some initial difficulties engaging health board management and clinical staff, as transport was not felt to be a priority issue. There was also some staff resistance to the new operating procedures. However, the formation of the Local Project Board to manage the pilot reportedly improved engagement significantly.

3.28 At the outset of the pilot there was limited capacity available to support the project, with the responsibility for driving forward the majority of initiatives resting with one member of the WAST management staff. However, subsequently, more expertise was recruited to address this issue.

Value for money

3.29 Efficiency savings resulting from the achievement of pilot objectives, such as a reduction of aborted journeys, or more consistent application of the eligibility criteria, would suggest that the pilot has the potential to generate value for money. There are early indications that this may be occurring, for example staff comments stating that the online booking system has cut down on the time they usually spend arranging transport. Additional data will help to clarify if and how the BCUHB pilot is providing value for money.

4 Cardiff and Vale

Background

4.1 Cardiff and Vale University Health Board (CVUHB) provides health services to a population of approximately 465,700 people living in Cardiff and the Vale of Glamorgan. It also serves a wider population across South and Mid Wales for specialties such as paediatric intensive care, renal services, cardiac services, neurology, bone marrow transplantation and medical genetics. Therefore, although the health board covers the smallest geographic area of all the pilots (471km²), its services are available to a much wider catchment area, including patients from England.

4.2 CVUHB manages nine hospitals: Barry Hospital, Cardiff Royal Infirmary West Wing, Children's Hospital for Wales, University Hospital Llandough, Rookwood Hospital, St. David's Hospital, University Dental Hospital, University Hospital of Wales (UHW), and Whitchurch Hospital. CVUHB also manages seventeen health centres, as well as providing services in health centres run by NHS partner organisations, both within Cardiff and the Vale and beyond.

The pilot

4.3 The pilot was designed to develop and implement an enhanced rapid discharge service⁴ using a social enterprise approach.

4.4 The pilot was implemented in three phases:

- **Phase 1** (06/12/2010) - St. John Cymru to take responsibility for the existing WAST Dedicated Discharge Vehicle for unplanned discharges operating out of UHW;
- **Phase 2** (01/04/2011) - St. John Cymru to take responsibility for all planned discharges and transfers operating out of UHW;
- **Phase 3** (05/09/2011) – St. John Cymru to take responsibility for all discharges and transfers across all remaining CVUHB hospitals.

⁴ Discharge transport is divided into planned and unplanned discharge. Planned discharge is defined as a discharge that is expected and planned well in advance. Unplanned discharge is discharge undertaken at short notice, and generally requested "on the day".

4.5 Following the implementation of the three pilot phases, St. John Cymru assumed sole transport responsibility for all planned and unplanned discharge and transfers from all CVUHB hospitals⁵. St. John Cymru now operates three dedicated vehicles based at two hospitals (University Hospital Cardiff and Llandough Rockwood Hospital) in order to provide a planned discharge service over and above the patient transport service provided by WAST. In addition, alongside the pilot, St. John Cymru has two dedicated vehicles for unplanned discharge based at UHW.

Objectives

4.6 The objectives for the pilot, as established from the Invest to Save funding bid, are to:

- establish a flexible and responsive discharge service, with the aim of reducing delayed transfer of care; and
- to improve overall patient experience.

4.7 Data on the impact of the pilot were obtained from a variety of sources. Quantitative indicators of performance, such as waiting times and journey times, were extracted from KPI reports provided to the NPB. Feedback on the pilot from staff and patients was gathered through interviews with ward staff and clinicians, as well as a survey of patients.

4.8 The patient survey was designed with the assistance of Cardiff & Vale Community Health Council (CHC) and included with the more general 'Hipo Survey'. 193 responses were received, resulting in a 70 per cent response rate. Responses were analysed using SNAP software.

A flexible and responsive discharge service

4.9 The clinical staff at UHW described the service from St. John Cymru as more than adequately meeting their requirement for flexibility and responsiveness.

Examples cited included:

- the ability to track vehicles on the Cleric system, enabling administrative staff to schedule unplanned discharge based on vehicle movements in real time;

⁵ This is with the exception of patients who require a trained paramedic to travel with them; these patients remained the responsibility of WAST.

- the clinical staff responsible for booking unplanned discharge now have the ability in Cleric to simultaneously view the schedule for planned discharge; and
- the manner in which ambulance staff approach their work, seeking to be as supportive as possible to the clinical areas.

4.10 Prior to the pilot, the provision of extra transport during times when hospitals are particularly busy or expected to be busy - for example when there are major international matches taking place at Cardiff Stadium - incurred an additional cost. However, the current contract with St. John Cymru allows for this supplementary provision, including the transport of patients to out-of-area locations such as England. Staff at UHW referenced the flexibility to source additional vehicles when necessary as a positive feature of the pilot.

4.11 This feedback gathered from ward staff also highlighted the 'direct-dial' facility into St. John Cymru as improving the flexibility and responsiveness of the booking process. This facility makes it possible for staff to book transport directly from the ward, rather than having to arrange transport through the ambulance liaison office.

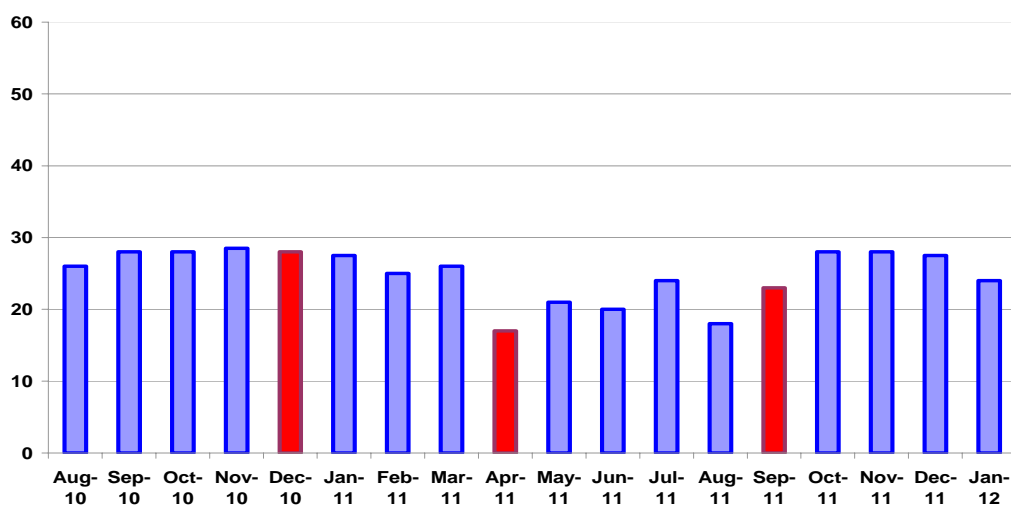
4.12 There is some qualitative, though unverified, evidence to suggest that the pilot may be having an effect on reducing the delayed transfer of care. Clinical staff in the UHW lounge believed that patients requiring transport were being discharged up to 24 hours earlier than they might have been in the past, thus improving overall patient flow throughout the hospital.

Improved patient experience

Reduced waiting times

4.13 The KPI reports to the National Programme Board include monthly data updates on the average time patients spent waiting in the UHW discharge lounge. Data are available for the period August 2010 to January 2012. These figures encompass waiting times for both planned and unplanned discharge, and therefore can only be taken as an indication of the impact of the pilot on waiting times for discharge as a whole.

Graph 4: Cardiff & Vale average waiting times (minutes) in discharge lounge, August 2012 – January 2012



4.14 Graph 4 shows small initial reductions in patient wait times coinciding with the introduction of phases 1 and 2 of the pilot. In December 2010, when phase 1 of the pilot was implemented, the average waiting time for discharge was 28 minutes. This then declined slightly over the following months and, as of the latest month for which data is available, the average waiting time in UWH has not exceeded 28 minutes. Following the introduction of the phase 2 of the pilot in April, the average waiting time for discharge dropped to 17 minutes, reduced from 26 minutes in March.

4.15 In contrast, the introduction of phase 3 of the pilot coincided with a rise in average waiting times from 18 minutes in August to 23 minutes in September. It is feasible that the expansion of St John Cymru’s transport provision across CVHB during phase 3 would have diverted vehicle resources from UHW and resulted in increased waiting times for discharge.

4.16 However, it should be noted that there is only a small amount of variation across the data overall; eleven and a half minutes between the highest and lowest wait times during the 18 month period. It is currently unclear to what extent the observed differences in waiting times by month are the result of natural fluctuations across the time period. Further monitoring of waiting times throughout the life of the pilot may help to clarify this further.

4.17 In response to the patient survey, 71 per cent of patients reported that they were picked up on-time, with an additional 12 per cent indicating that they were not given a specific time for pick-up. 37 per cent of patients noted they waited more than an hour for transport, although a similar proportion responded that they waited less than 30 minutes.

Journey times

4.18 KPI reports provided to the NPB show the proportion of patients completing their return journey within one hour of discharge. Given the evolving nature of the KPI dashboard, data from this indicator were only collected from June 2011 onwards. It is therefore not possible to determine if journey times were reduced following the implementation of phase 1 of the pilot.

4.19 Between June 2011 and January 2012 the proportion of patients completing their return journey within one hour of discharge has remained between 90 per cent and 95 per cent. In addition, the data shown in Table 4 suggest no marked differences in journey times between phases 2 and 3 of the pilot. This is particularly notable given the four-fold increase in out-of-area journeys following the implementation of phase 3.

Table 4 Cardiff & Vale Patients transported under 1 hour and out-of-area, by month

Description	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 12
				Phase 2					Phase 3				
Number % patients transported under 1 hour						237 93.3%	264 90.1%	265 91.4%	424 92.6%	364 95.0%	371 91.4%	376 91.3%	370 93%
Number of "out of area" journeys	28	37	40	25	31	17	20	25	101 22%	94 25%	93 23%	95 23%	98 25%

Patient feedback

4.20 Patient feedback has also highlighted a high level of satisfaction with the transport facilities provided. 95.5 per cent of respondents rated their whole experience as excellent or good. These responses reflected satisfaction both with the transport staff, as well as the vehicles used for discharge. 99 per cent of patients providing feedback rated the staff as excellent or good, and 97 per cent rated the

vehicle as excellent or good. However, research suggests that satisfaction scores are often high when asked on or around the time a service is provided, therefore moving forward it will be useful to capture patient satisfaction using a combination of indicators⁶.

4.21 Of the few patients who responded that their experiences had been negative, complaints centred on their level of comfort during the journey. For example, one respondent reported their journey being noisy, bumpy, and cold. St. John Cymru have addressed this feedback by ensuring drivers are aware of the concerns about bumps, and have advised on the need to keep vehicle doors closed as much as possible when dropping off patients if there are other passengers on board. In addition, blankets are now made available to all passengers during their journey.

Evaluation against the Griffiths' criteria

Timeliness and journey times

4.22 Waiting times for discharge have ranged between 17 and 28 minutes over the 18 month period for which indicators are available. Given the small variation in the data it is currently difficult to determine if reductions in wait times can be attributed to the pilot, or whether the observed differences in wait times by month are a result of natural fluctuations across the time period. Further monitoring of wait times throughout the life of the pilot may help to clarify this further.

4.23 Patient feedback shows that 71 per cent of patients reported that they were picked up on-time. However, there is some indication that patients may not have interpreted 'pick-up time' in a consistent way. Future questionnaires will aim to clarify this issue.

4.24 With 90-95 per cent of journeys completed within one hour, it appears journey times are reasonable. In addition, the proportion of journeys completed within one hour has remained at this high level despite the fact that phase 3 of the pilot has significantly increased the demand placed on St. John Cymru vehicles.

⁶See MORI (2002) 'Public Service Reform: Measuring and Understanding Customer Satisfaction.' London: MORI

Responsiveness to clinical and patient requirements

4.25 Consultation with St. John Cymru staff revealed that increased responsiveness to clinical and patient requirements was one of their main aims in operating the service. Interviews with clinical staff, as well as the pilot lead and access manager, showed that the current discharge service is regarded by staff as more flexible and responsive to their requirements than previous arrangements.

4.26 Staff also reported that St. John Cymru were better able to meet the needs of patients than the previous discharge service. Staff cited the willingness of St. John Cymru to transport patient bags and equipment (walking frame, crutches, etc.) as providing an improved service for patients.

Joined up working / integration

4.27 Prior to the start of the phase 1 of the pilot, a local project board was established which has reportedly improved communication between all stakeholders, including CVHUB, St. John Cymru, hospitals, WAST and the CHC.

4.28 Background work by the local project board resulted in a service specification being drawn up between CVUHB and St. John Cymru. This specification formalises a commitment to partnership working and outlines priorities for developing services. As part of this partnership agreement CVUHB and St. John Cymru meet monthly in order to monitor pilot operations and performance. This includes sharing data on KPIs, patient experience, operations and finance.

4.29 There has been evidence of joined-up working throughout the pilot. For example, in the early stages of the pilot, both the CVUHB IT department and WAST worked with St. John Cymru to ensure that staff were able to use the reporting functions in Cleric to generate the required KPI reports for the National Programme Board.

Good practice approaches

4.30 The patient feedback survey has served as a valuable source of information for the project, and the findings have been made available to the NPB. The survey is intended to continue for the duration of the pilot, with questionnaires being administered to patients on a quarterly basis. CHC is optimistic that this practice will

provide a useful model for other pilot areas that wish to develop mechanisms for capturing patient feedback.

4.31 The pilot has resulted in the development and collection of a number of performance indicators, many of which were unavailable before the inception of the project. In the original specification for the pilot, the local project board worked to identify key qualitative and quantitative performance criteria necessary to inform on outcomes. The building of this indicator base has been a key achievement of the project, and should be encouraged across all pilot areas.

Barriers to success

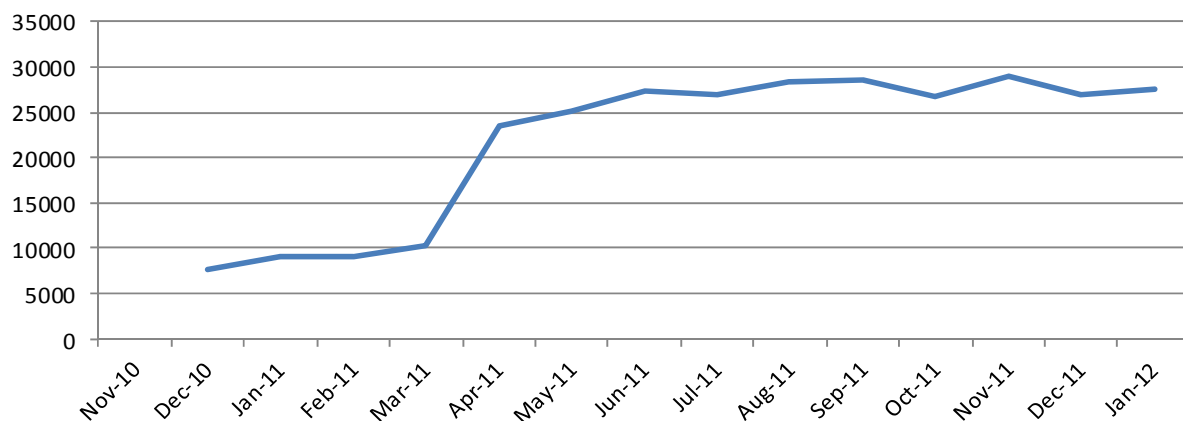
4.32 During the planning stages of the pilot, the project board were faced with a potential budget shortfall. Initial projections of the savings that would accrue from WAST no longer being required to provide discharge and transfer services were estimated at £330,000, which was considered adequate to support the pilot. However, this figure was eventually revised downwards to £150,000, leaving a need to identify a source of funds to meet the shortfall. The Welsh Government ultimately agreed to bridge the funding gap of £180,000 on a temporary basis.

4.33 Consultation has indicated recent difficulties in clarifying the respective responsibilities of each organisation in cases where patient's needs are serious and require additional support outside of St. John's standard provision. There are currently significant efforts being made between CVUHB, WAST and St. John Cymru to define relative areas of responsibilities in a way that minimises any disruption to the patient.

Value for money

4.34 The available cost data shows that the original estimate of £300,000 per year to operate the pilot has been accurate, with average cost/month to date being approximately £28,000, which over a twelve-month period would equate to approximately £330,000. The costs clearly show the introduction of phase 2 in April 2011.

Graph 5: Cardiff & Vale Cost per month £s, November 2010- January 2012 for St John discharge vehicles



4.35 At this stage of the pilot it is difficult to assess if the service provided by St. John Cymru provides value for money over the previous arrangements. Further financial data would help to clarify this, in particular the quantification of any savings generated from the inclusion of ECR activity in the contract between CVUHB and St. John Cymru⁷.

⁷ The CVUHB contract with St. John Cymru includes out of area (ECR) activity. Under its previous arrangements with WAST, CVUHB was charged for these journeys on a cost per case basis over and above the SLA.

5 Cwm Taf

Background

5.1 Cwm Taf Health Board was established on the 1st October 2009 following the integration of the former Cwm Taf NHS Trust, Merthyr Tydfil Local Health Board and Rhondda Cynon Taf Local Health Board. The health board spans four localities: the Cynon Valley, Merthyr Tydfil, the Rhondda Valleys and the Taff Ely area, and serves a population of approximately 289,400 people. Services are also provided to the people of South Powys, North Rhymney, North Cardiff and other adjacent health community areas, as well as some specialist services to the wider catchment area in South Wales.

5.2 The Griffiths Review highlighted that patient services in the area were seen as fragmented and disjointed. Patients determined as eligible for transport were referred to the individual Ambulance Liaison Desks in each receiving hospital in order for their transport to be managed. In addition, the review found that providers were often focused on their own performance rather than working in partnership to improve delivery.

The pilot

5.3 The Cwm Taf pilot was designed to establish an integrated communications centre that would serve as the sole point of contact for all bookings of non-emergency patient journeys. The pilot also sought to implement a more consistent and effective application of the eligibility criteria for transport in order to ensure that resources were being directed where they were most needed.

5.4 The communications 'hub' came into operation in 2011 and is staffed by up to seven call operators who deal with as many as 500 calls per day. The hub is located within the RCT local authority premises, and utilises a communication system jointly with RCT.

Objectives

5.5 The pilot objectives are as follows:

- integrate the two IT systems used in the regional booking centre and the WAST transport planning centre;
- reduce the amount of double entry, potential for error, and improve data handling; and
- ensure eligibility criteria for transport are consistently applied.

There are also longer term objectives to integrate non-emergency patient transport provision with the social care transport provision provided by local authorities.

5.6 While pilot activity was initially restricted to the Cwm Taf population, this has been subsequently rolled out to Gwent and Cardiff and Vale, releasing the potential benefits of the pilot to a much wider population.

Integrated IT systems

5.7 There has been a successful transition of the non-emergency ambulance booking system from AdAstra to Cleric. In addition, staff report finding Cleric easier to use than the previous system, citing a better on-screen layout.

Improved data handling, reduced error and duplication

5.8 Integrating IT systems has improved data handling by introducing consistency between providers in how data are inputted. Previously, the booking of non-emergency patient transport via the AdAstra system required the use of different fields to those used by Cleric, including several free text fields.

5.9 The communications hub has streamlined the booking process for non-emergency patient transport by removing the necessity to fax first requests for non-emergency transport through to WAST. Prior to the pilot, requests for transport were initially processed at Ty Elai in Tonypany. Once eligibility had been determined, the information was faxed to the South East ambulance centre at Vantage Point where route planning was undertaken by WAST. In addition to this, WAST also received requests for transport directly from hospitals and renal services.

5.10 Dashboard data reported to the National Programme Board show the positive impact of this streamlined process. In December 2010, before the integration of the IT systems, 3258 faxes requesting transport were sent from Ty Elai to Vantage Point. By December 2011, after the integration of the IT systems, this number had dropped to 0. Concurrently, the number of staff hours utilised to handle faxes and then re-enter them onto Cleric by WAST at Vantage Point has reduced from 528 hours per month in December 2010 to 0 hours in December 2011. This equates to staff cost savings of approximately £70,000 per year⁸.

Consistently applied eligibility criteria

5.11 Staff reported that Cleric's assessment script led them through the eligibility criteria more systematically than the previous AdAstra system, enabling more consistent processing of first requests for transport. Staff were also positive about the additional mobility categories contained within Cleric; nine versus the five available in AdAstra. This has allowed staff to provide better information to transport planners in WAST, and has also reduced the need for staff to respond to follow-up calls made by WAST to clarify transport requirements.

5.12 The Cleric system also enables staff to access information on transport alternatives for applicants do not qualify for services. Telephone operators are shown postcode-generated transport options on their screens, allowing them to provide that information directly to the caller. Therefore those who are ineligible are offered information about alternative transport providers in their area, for example, community transport schemes.

Evaluation against the Griffiths' criteria

Timeliness and journey times

5.13 This pilot is not designed to impact timeliness and journey times of patient journeys.

⁸ Based on 528 hours per 4 weeks = 132 hours per week = 37.7 hours x 3.5. Assuming a nominal cost per FTE of £20,000 for an administrative/clerical grade, this would equate to staff cost savings of approximately £70,000 p.a. This equates to approximately 3.5 full-time equivalent staff at Vantage Point. However these financial savings accrue to WAST rather than Cwm Taf HB.

Responsiveness to clinical and patient requirements

5.14 Cleric offers a number of reporting functions which have the potential to increase responsiveness to clinical and patient requirements. The system has the ability to provide useful data such as the monitoring of cancellation rates by particular users, or patterns of non-attendance.

Joined up working/integration

5.15 The ultimate aim of the communications hub is to provide a single point of contact to book several health services alongside non-emergency patient transport, including GP out of hours' services, emergency dental services and district nursing services. Currently there are plans to cross-train staff with the team from the Medical Records directorate who deal with Myrddin, the hospital appointment booking system, which is located in the same room as the booking centre.

Good practice approaches

5.16 The integration of the two IT systems has added clarity and consistency to the booking process and has also met with a positive response from staff. In addition, the switchover to Cleric enables staff to provide relevant information about alternative forms of transport to patients who do not qualify for non-emergency transport services.

Barriers to success

5.17 Plans to integrate Myrddin with Cleric, thus allowing more joined-up working between the booking of hospital appointments and the booking of non-emergency patient transport, have met with practical problems around the compatibility of the software systems.

Value for money

5.18 At this stage of the pilot it is difficult to conclude whether the investment made at Ty Elai in integrating systems and training staff provides value for money. The reduction in data duplication and errors through integrating systems, as well as more consistent implementation of the eligibility criteria for transport, would seem to indicate more efficient handling of requests for non-emergency patient transport. However, further financial data will need to be generated in order to determine if this is the case.

6 Hywel Dda

Background

6.1 Hywel Dda Health Board spans the local authority areas of Ceredigion, Carmarthenshire, and Pembrokeshire. The region is primarily rural with a total population of about 372,320. The area includes four general hospitals: Bronglais in Aberystwyth, Glangwili at Carmarthen, Prince Phillip at Llanelli, and Withybush at Haverford West.

6.2 The pilot builds on initial work carried out in 2008 by the Three Counties Transport Services Planning Group. This work identified potential operational transport synergies that existed between agencies, as well as the need to develop an integrated non-emergency transport system.

The pilot

6.3 The aim of the Hywel Dda pilot is to develop an integrated transport service that will result in the more efficient use of transport resources. The pilot commenced in December 2010 and was branded ICARHS – Improving Customer Access to Rural Health Services.

6.4 A key component of pilot activity has been the utilisation of local authority social care vehicles during their usual hours of non-operation to support hospital discharges and transfers. Social care vehicles now currently operate at four district general hospital sites and four community hospital sites.

6.5 In addition, the pilot has resulted in the assignment of a dedicated Community Voluntary Transport Vehicle to meet the non-emergency patient transport needs of the Mental Health Day Unit.

Objectives

6.6 The main objective of the pilot is as follows:

- to integrate transport service provision to secure efficiencies through the coordinated and maximised use of transport resources in the voluntary, statutory and private sectors.

6.7 Progress towards achieving this objective is measured in terms of:

- improved utilisation of assets;
- reduction in patient waiting times; and
- financial savings.

There are also longer-term objectives to ensure that the provision of non-emergency patient transport is aligned with the Five Year Strategic Framework, and that the pilot should result in a 'whole-systems' approach to non-emergency patient transport.

Improved utilisation of assets

6.8 Data provided to the NPB shows an increase in the use of social care vehicles for non-emergency patient transport journeys following the introduction of the pilot. Figures from August 2010 to August 2011 show that social care vehicles carried out an average of 2 per cent of non-emergency patient journeys (119 journeys) from August to December 2010 (pre-pilot), and 6 per cent of journeys (484 journeys) from January to August 2011. This four-fold increase demonstrates improved utilisation of public resources across the health board, as these vehicles would usually sit idle during the time they are now available to meet transport needs.

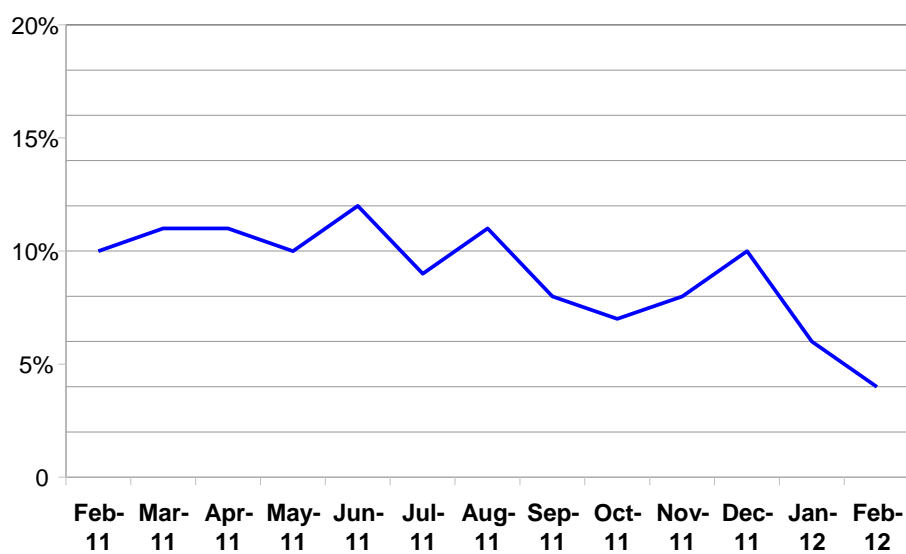
6.9 However, given the continually developing nature of the data, it is difficult to determine if this improved utilisation of transport resources has continued across the entire time period. After August 2011, the relevant KPI was refined to include voluntary sector vehicles, making comparison with the previous time period problematic. For September 2011 to February 2012 an average of 8 per cent of non-emergency patient transport journeys were carried out using social care or voluntary sector vehicles, although it is possible this rise can be attributed to the change in the way that the KPI is measured.

Reduction in patient waiting times

6.10 From August 2010 to February 2012 there were an estimated 117,291 non-emergency patient transport journeys in the Hywel Dda area. Transporting outpatients to and from day treatment centres accounts for 88 per cent of all journeys. 8 per cent of journeys are for discharge from hospital, with the remaining few percent of journeys being made to admit a patient to hospital, or to transfer a patient between hospitals.

6.11 Graph 6 shows that over the last 12 months there has been evidence of improvement in the number of patients waiting more than two hours for discharge. Patient waiting times have declined steadily since December 2011, reaching their lowest point in February 2012, the most recent month for which data is available. Further monitoring of this KPI will determine if this finding is a result of a temporary fluctuation in the data, or if these improvements are sustained over time.

Graph 6: Hywel Dda: Percentage of discharge patients waiting more than two hours for discharge, February 2011 – February 2012



However, as previously noted, discharge journeys represent only a small fraction of non-emergency patient transport activity, and the small number of patients in the dataset means that percentage changes should be treated with caution. For example, in Graph 6, the 2 per cent drop in the number of patients waiting more than two hours for discharge between January and February 2012 represents a difference of just six patients.

6.12 Data for out-patient waiting times is a relatively recent KPI, and continued monitoring of this indicator over time will help to determine if waiting time for these patients is also being reduced as the pilot develops. As outpatient journeys account for the majority of non-emergency patient transport activity, this will be a key area to focus on in assessing pilot impact.

Financial savings

6.13 In some instances changes to transport provision have reduced inefficiencies, which would imply that financial savings are occurring. For example, the use of a dedicated volunteer vehicle to convey mental health patients attending St. Brynachs Day Hospital (see 6.20) has resulted in the aborted journey rate for these journeys falling from 13 per cent to 4 per cent. In addition, clinicians reported that they liked the reliability of this dedicated transport, and that having consistency of staff was reassuring, particularly to EMI patients.

6.14 Since September 2011, procurement for ECRs has taken place through a single point of contact within the health board. The new system requires each ECR to be reviewed for eligibility and a need for transport. Three quotes are then obtained from transport providers and the most cost-effective and suitable resource is selected. Reports to the NPB suggest that this process has currently saved the health board over £26,000⁹.

Evaluation against the Griffiths' criteria

Timeliness and journey times

6.15 The Hywel Dda customer satisfaction survey (see 6.16) shows that for the majority of respondents, timeliness was not seen as a problematic issue. The vast majority of respondents (91 per cent) answered that they either 'Very Satisfied' (79 per cent) or 'Fairly Satisfied' (12 per cent) with the punctuality of their transport and their waiting times. The survey also shows that the same percentage of respondents reported that they were 'Very Satisfied' (80 per cent) or 'Fairly Satisfied' (11 per cent) with their journey time, despite the fact that in rural health board areas the door-to-door journey time is often longer than in non-rural areas due to the wide catchment areas of clinics and hospitals¹⁰.

Responsiveness to clinical and patient requirements

6.16 Stakeholder engagement has been a strong feature of the Hywel Dda pilot. A number of Citizens' Panel surveys and stakeholder consultations have been

⁹ Estimates for September 2011-February 2012.

¹⁰ Survey results based on 378 respondents surveyed between August 2011-March 2012. Once again, caution is recommended in the use of satisfaction scores as a sole measure of service quality (see 4.20).

undertaken with the intent of collecting information on the perceptions of non-emergency patient transport services and suggestions for improvement. In addition, a customer satisfaction survey has been made available across Hywel Dda for users of non-emergency patient transport. Feedback received from patients has been used to assist with the redesign of services

6.17 Social care vehicles have proven better able to meet the needs of patients who require luggage or equipment to be transported with them, for example crutches or a wheelchair. This is in contrast to the service provided by WAST who, for capacity reasons, are often unable to transport additional items with a patient. Comments from user engagement exercises have highlighted that one of the key benefits of social care vehicles to patients and clinicians was that they were regarded as more flexible and willing to accommodate equipment as needed on the day.

Joined up working / integration

6.18 The pilot has been extremely proactive in achieving considerable joined up working. Originally set up across the health and local authority area in Carmarthenshire, it now involves three local authorities and the health board at both management and operational levels, with good working relationships between colleagues in different sectors. There has also been integration of transport provision across the health, voluntary, and local authority sectors, enabling the area to move closer to the 'mixed-economy' of non-emergency patient transport referred to in the Griffiths' Review.

6.19 There is also evidence of greater collaboration between the health board and WAST as a result of the pilot, with WAST now able to access the Myrddin patient system and cross-check transport bookings with hospital appointments.

Good practice approaches

6.20 The pilot undertook a significant amount of behind-the-scenes work to better understand the picture of non-emergency patient transport in the region, as well as the views of users and stakeholders. In addition to the user survey and citizen and stakeholder panels mentioned previously, additional analysis was conducted across the region to help identify potential improvements that could be made to the service.

For example, a six-sigma approach to reduce the level of aborted journeys revealed particularly high levels of abortions from EMI clients. This prompted the use of dedicated vehicles for St Brynanch's and Bro Cerwyn Day Unit (EMI), which ultimately resulted in a reduced rate of aborted journeys.

Barriers to success

6.21 There is the potential for additional health board initiatives to impact on the achievement of pilot objectives. For example, the renal network specifies transport targets for renal patients, and anecdotal evidence from consultation suggests that the achievement of these targets may have implications for the level of resource available to the pilot.

Value for money

6.22 The direct procurement of ECRs (see 6.14) has resulted in demonstrably reduced costs, and has currently saved the health board an estimated £26,000.

6.23 Further analysis of the effect on the pilot on reducing delayed transfer of care has the potential to demonstrate financial savings, and provides evidence that increasing resources provide value for money. For example, the late afternoon discharge vehicle and daytime vehicle allocated to Bronglais has operating costs of approximately £27,000 per year. If 60 or more overnight hospital stays a year were avoided by transport being available, then this service would be self-financing.

7 Conclusions and Recommendations

7.1 This interim evaluation was commissioned to evaluate the four pilot models of non-emergency patient transport established in response to issues identified by the Griffiths review. The purpose of the research was to identify the extent to which the four pilot areas have been successful in improving non-emergency transport services.

7.2 Notable progress has been made by the pilots so far in delivering improved services, particularly in terms of process improvements and collaboration in and across the pilot areas. The NPB has also played a significant role in the coordination and monitoring of the pilots, as well as functioning as a vital forum to enable the sharing of best practice and the dissemination of learning.

7.3 Given that the pilots are still in their preliminary stages, this interim evaluation is not yet able to assess the extent to which changes to non-emergency patient transport have resulted - or will result in - an improved patient experience. The current evidence base is not yet developed enough to draw reliable conclusions about pilot outcomes. Moving forward, the continued development and monitoring of relevant performance indicators, and a summative evaluation of the pilot outcomes, will be important in establishing the pilots' impacts.

The pilots

7.4 There is initial evidence to suggest that the pilots are developing improved processes, with each health board demonstrating progress towards fulfilling its own pilot-specific objectives. Table 5 summarises notable improvements to service delivery resulting from pilot activity. Future work should aim to clarify which successes are a result of context-specific factors, such as the concomitant roll-out of other initiatives, and which successes are attributable to pilot design and therefore transferable to other regions.

Table 5: Early pilot successes

Area	Success
Betsi Cadwaladr	Rollout of online booking Significant reduction in number of patients waiting more than 2 hours for discharge Revised control room roster allowing for extended operating hours Introduction of automated text messaging transport reminders Implementation of performance dashboard highlighting KPIs to staff Improved discharge pathway Efficiency savings
Cardiff & Vale	Flexibility to source additional vehicles when needed Introduction of 'direct-dial' Reduction in the delayed transfer of care Good working relationship established between clinical staff and ambulance staff Potential model identified for survey of patient experience using Hipo
Cwm Taf	Successful integration of 2 IT systems to reduce double entry/reduce errors and staff time Effective use of Cleric to improve data management and data handling, and improved categorisation of transport needs Streamlined booking process Improved referral to other providers for non-eligible patients
Hywel Dda	Collaboration at local management and operational levels between local authority and health board Six sigma analysis to identify specific problems and improve understanding of system Improved process for procurement of ECRs, resulting in financial savings. Improved utilisation of public resources through use of local authority transport resources in down time Dedicated transport for EMI clients leading to a drop in aborted journeys

Griffiths' Review

7.5 In addition to progress against specific objectives, the pilots have also shown some measure of success in addressing the Wales-wide issues with non-emergency patient transport that were highlighted by the Griffiths' Review, such as:

Timeliness and journey times

7.6 Although still in the early stages of monitoring, there have been recorded improvements in timeliness and journey times across three of the pilots¹¹. Betsi Cadwaladr shows a slight reduction in average journey times since the start of the pilot, and Hywel Dda shows a significant reduction in patients waiting longer than two hours for discharge. Performance indicators for Cardiff and Vale show that 90-95 per cent of journeys are completed within 1 hour, with patients expressing a high degree

¹¹ The Cwm Taf pilot was not designed to address timeliness or journey times

of satisfaction with the transport service. Further monitoring of performance data over time will be necessary to clarify the true impact of pilot activity on timeliness and journey times overall.

Responsiveness to clinical and patient requirements

7.7 There are examples of initial successes across the four pilots in altering non-emergency patient transport provision to be more responsive to clinical and patient needs. Two of the pilots were able to make available additional transport resources, allowing clinicians more flexibility in booking transport. These additional resources were operated by third sector partners, which also meant they were more able to respond to the needs of patients. For example, St. John Cymru had the capacity to carry additional luggage with patients where WAST did not. The dedicated transport provision for EMI patients in Hywel Dda is also an example of pilot activity designed to respond to the requirements of a particular set of patients.

Joined up working / integration

7.8 There has been strong evidence of joined up working and integration across the pilots. The Betsi Cadwaladr pilot has led to improved collaboration between stakeholders, and as a result of successful activity there are future plans to integrate the delivery of social care transport and non-emergency patient transport. Similar coordination in the delivery of transport services across providers has occurred in Hywel Dda, and a formal commitment to partnership working between CVUHB and St. John Cymru has been a feature of the Cardiff and Vale pilot. In addition, Cwm Taf health board successfully integrated IT systems and is working towards the cross-training of staff.

Value for money

7.9 Value for money is difficult to assess at this stage of the pilots, but there are instances where financial savings would be expected to occur due to the implementation of more efficient processes. Examples of these include the reduction of aborted journeys in Betsi Cadwaladr, the reduction in data errors and duplication in Cwm Taf, and a reduction in the delayed transfer of care in Cardiff and Vale. One area where efficiency savings have already been generated is the new procurement process for ECRs in Hywel Dda, with estimated savings of £26,000 in its first six months of operation.

7.10 The capturing of administrative data would aid in the estimation of financial savings due to accrue from increased efficiencies. Currently there is anecdotal evidence that substantial savings in staff time have occurred as a result of pilot activity, but this is not yet able to be quantified in a systematic way.

7.11 In order to better assess value for money there should be a strong focus on the development and collection of consistent and comparable financial indicators as the pilots move forward.

Role of the National Programme Board

7.12 The NPB has played a significant role in the coordination and monitoring of the pilots, and has had particular success with ensuring performance indicators were established and regularly reported.

7.13 The NPB has also facilitated dialogue between health, local authority, and voluntary sectors, enabling a joined-up approach to delivery. Through regular meetings and workshops it has served as a vital forum to enable the dissemination of learning among stakeholders and the sharing of best practice. Local project boards have also complemented NPB activity by providing an umbrella for local joint working on practical issues around implementation.

Further considerations

7.14 The establishment of performance indicators and the regular monitoring of data collection for each of the pilot projects has been a key achievement, particularly considering the low baseline of data availability from which the pilots began. Moving forward there is a need to establish a number of high-level metrics for all health board areas to ensure time-series and benchmarking data is available. This will make it possible to place outcomes in pilot areas in a national context of overall trends, and better enable the assessment of impact. Table 6 provides recommended indicators that could be used for this purpose going forward, many of which are already collected in some form across health boards.

Table 6: Recommended high-level performance indicators

PROPOSED INDICATOR	PROS	CONSIDERATIONS
Cost per journey	Provides an indication of value for money Allows comparison across different modes/providers of transport	Clear and consistent definition of cost is needed, or indicator may be incomparable across service providers or regions Cost per journey may rise with improved service delivery
Journeys per capita	Allows benchmarking across health boards on the volume of service provided / level of demand	Should take account of all transport providers, not just WAST
Percentage of aborted journeys	Already collected in most cases Provides indications of efficiency and joined-up working	Should take account of all transport providers, not just WAST Capturing the reason for an aborted journey may help to identify areas for action
On time collection/arrival/ departure	Provides indication of timeliness unrelated to overall waiting times or journey times (which may be longer in rural health boards)	Needs careful definition of “on time” collection/arrival/departure – e.g. appointment time vs. time a patient is told to be ready for transport
Customer satisfaction with transport	Allows qualitative information to be captured. Provides indication of overall patient experience	Consistent survey question needed across health boards and across time in order to facilitate comparison Additional mechanisms for capturing patient satisfaction need to be developed
Clinician satisfaction with transport	Provides an indication as to what extent non-emergency patient transport is meeting clinical requirements	Consistent survey question needed Comparison across health boards may provide an indication as to which model of service delivery best meets clinical requirements.

7.15 It would be useful if high-level indicators were collected in such a way that they could also be disaggregated down beyond the regional level. Within each pilot area, many initiatives were implemented in a single clinic or department before being rolled out to other sites. Given that data is currently reported primarily at the regional or health board level, the effect of these initiatives is harder to discern. This would also provide the advantage of enabling the comparison of performance indicators across pilot and non-pilot sites within the same health board.

Recommendations

7.16 All four pilots have demonstrated progress towards achieving their pilot-specific objectives and to addressing the issues with non-emergency patient transport identified by the Griffiths Review. At this early point in time, process improvements made by the pilots constitute the main bulk of evidence that suggest improved service models are developing. Future work will be better placed to evaluate the impact of the pilots i.e. whether improved service models are delivering better outcomes for patients. It is recommended that an evaluation framework for the summative evaluation be developed as soon as possible so that there is sufficient time to gather relevant data.

7.17 Moving forward the pilots would benefit from the establishment of high-level performance indicators to allow for comparisons across health boards. However, these indicators should be collected in such a way that does not preclude disaggregation, in order to also allow comparisons within health boards. Indicators should capture both qualitative and quantitative measures, and record relevant pilot activity for all providers (i.e. not just WAST).

7.18 Additional mechanisms for capturing patient satisfaction with transport services should be developed to supplement findings from the feedback collected from patients at or around the time of transport.

7.19 In order to better assess value for money there should be a strong focus on the development and collection of consistent and comparable financial indicators as the pilots move forward.

7.20 The NPB plays a vital role in the coordination and monitoring of the pilot projects, and it should continue its work in facilitating dialogue between stakeholders and identifying areas of promising practice which can be further investigated, understood and applied elsewhere. In addition, the NPB should continue to lead in the development of national and local performance indicators, with a view to establishing an evidence base that will enable future measurement of real improvements in the patient experience.