UNISON
the public service union

Patient Transport Services

The impact of privatisation and a better way forward

Contents

Report on Patient Transport Services – the impact of privatisation and a better way forward

This paper is written on behalf of UNISON by Richard Bourne.

UNISON is the major trade union in health and social care and the largest public service union in the UK. UNISON represents more than 450,000 healthcare staff employed in the NHS, and by private contractors, the voluntary sector and general practitioners. In addition, UNISON represents over 300,000 members in social care. The union's community and voluntary sector has an expanding membership of more than 60,000 and UNISON has a large retired membership of more than 165,000 with a particular interest in the future of health and social care. In addition, there is a wider interest among our total membership of more than 1.3 million people who use, or have family members who use, health and social care services.

Richard Bourne has conducted many reviews into major projects and programmes for UNISON. He has also been part of over 70 Gateway Reviews, mostly in health, but also in local and central government. Until recently was a Gateway Programme Director at the Department of Health. He has extensive knowledge and direct experience of the care system and has worked on policy development at local and national levels.

He has worked as a Consultant in the public sector for 15 years mostly on case preparation, evaluation and assurance of major and high risk projects. He has also held executive and non-executive posts within the NHS and DH at Board level. Richard has experience in local and central government working as a Consultant and was a Councillor for 13 years.

With special thanks to UNISON members in ambulance services throughout England who provided a wealth of knowledge and experience; and to senior managers in commissioners, policy makers and providers who also assisted.

This report looks at the role of commissioning and the central decision to introduce a marketised approach to Patient Transport Services. We want to acknowledge the professionalism and dedication of the many staff working in difficult and challenging circumstances, doing their best for their patients and hoping for a better system, driven by quality of care and not profits.

April 2017

Introduction

This report began with an investigation into the experience of Patient Transport Service (PTS) staff transferred into the private sector. It rapidly became clear that this opened up the wider issue of fragmentation of the NHS and to the role of commissioning, leading to questioning of the current policy approach to provision of NHS services.

It examines the new approach being exemplified in the Sustainability and Transformation Plan (STP) process where cooperation and collaboration and a focus on better models of care and relationships are replacing the discredited approach of markets and competition.

As a result, this report looks at the recent history of piecemeal privatisation[1] of Patient Transport Services, but looking at this within the context of the drive for a more integrated urgent and emergency care system. It illustrates the experience of those who work in the service and the many concerns they raised about privatisation of PTS.

It also takes into account the potential for a more strategic look at how making decisions about the best place for patients to get care and then moving patients around the care system could be done far better – getting care to the patient as well as taking the patient to where care is provided. In doing this wider examination the conflict between privatisation and integration constantly recurs.

This report takes two views of privatisation. Firstly, looking at the impact of the fragmentation of this service from the patient experience, and secondly through the experience of the staff.

It provides the results of a survey, and of many interviews with staff, managers and commissioners about the reality of privatisation and the potential for a more integrated approach. It also draws from looking at various policy papers and guidance about the emergency care system, STPs documents, commissioning policies and contracts, and at ambulance services plans and strategies.

There is little if any actual evidence about the outcomes achieved by privatisation of PTS or its overall value within the care system, just as there is little or no evidence of any evaluation of the impact of the years of using competition for services as a policy lever. However, there is a wide consensus that if there have been any benefits from the recent trend in privatisation of PTS these are more than outweighed by the loss of opportunity to have a better more integrated service of which PTS is one part.

The report raises serious questions about the process of commissioning by Clinical Commissioning Groups (CCGs) and challenges its value in service improvement. This research shows how poor outcomes have their source in the policy of markets and competition and the inability of the commissioning process and commissioners to find suitable solutions.

Finally, the report looks at some new thinking about PTS, already being developed by commissioners, and suggests that there is a better way forward than piecemeal outsourcing.

[1] The terms privatisation and outsourcing are used synonymously throughout.

Executive Summary

Since 2013, the proliferation of private companies providing patient transport services has been, on balance, detrimental for the NHS and for patients. Some of the service provided by private companies has been substandard, verging on scandalous, and the experience of staff transferred to private providers in many cases has been poor.

Outsourcing NHS services has sadly been a backdrop for many years. With the development of STPs it appears the era of competition and privatisation is coming to an end. Much more thought is now being applied into how to join up various services in and outside the NHS to benefit patients, but also to make the whole system more sustainable.

The development of STPs also casts doubt on the wisdom of outsourcing single services within an integrated system. A far better model would be where a major NHS organisation, like an ambulance service, holds the overall contract as a 'lead provider' or 'system integrator'.

The model for ambulance services which allows patient transport to be hived off has always been flawed. The negative impact of weak commissioning and fragmentation of service provision has recently been recognised in relation to the core role of ambulance services. Commissioners who continue to regard PTS as a separate service that can reasonably be put out to competitive tender and managed through contracting should be challenged. A far better model is one where transport of patients is an integral part of an overall service.

It is now time to ensure STPs look more at the wider role of ambulance services; to not only integrate the whole urgent and emergency care system but also use the same resources to offer PTS. STP leaders should be encouraged to think again about the role of ambulance services in a more joined up care system.

Commissioning of PTS should be through ambulance services only; this does not exclude private providers it just means they must contract with the ambulance service and not directly with commissioners. This will provide greater clarity to accountability and governance as well as simplicity; regulation is also simplified and there is the opportunity to develop a single contract, KPIs and service model. Organisations like ambulance services will be far better at holding contractors to account than inexperienced CCGs and directly manage any contract failures.

Recommendations: A Better Way

Change the Mindset

The Health and Social Care Act (H&SCA) created a world of competing, autonomous, independent providers and expert commissioners. The best specifications and care models will be developed, not by multiple commissioners working in isolation, but by all relevant parts of the system working together. The experts in PTS are not commissioners they are the users and staff. Designing a "contract" as the basis for relationships within such a complex adaptive system as the NHS is futile. Contract management is a poor and ineffective substitute for joint working.

Widen the Scope

No consideration of PTS should begin from the premise that it simply moves patients from A to B. PTS has to be seen not as a separate service but as part of a wider integrated system for out of hospital care and a component of a joined up urgent and emergency care system. This has to be reflected in how staff are trained and developed and in what resources (vehicles and communications systems) are used.

National Standards and Single Operating Model

It is possible to design a single model for PTS with appropriate KPIs and data collection requirements – which should be developed with patients, users, staff, hospitals, GPs and ambulance services (as opposed to by commissioners in isolation). Equally, a single determination of staff roles and responsibilities fed into the Agenda for Change system would aid a consistent local application.

Cooperation

There is scope for a cooperative model in the Midlands (WMAS, EMAS, EEAS) and in the South (SWAST, SCAS, SECAM) around PTS which could see local variations around a single operating model, single set of KPIs, single clinical governance regime, single reporting structures and data collection.

The single model could then lead to a unified regime for staff training and development unified approach to Agenda for Change and opportunities around scale of procurement for vehicles, uniforms and supplies generally.

Alignment to STPs

It would make sense for there to be a single lead provider of PTS services (and indeed for all Urgent and Emergency Care services) for each STP footprint. This could only be an ambulance service if integration and flexibility were key requirements. Commissioning would be at a strategic level and would not have to deal with detailed contract compliance or design of the care model – that has already been done once.

Private Providers

There could be a continuing role for private PTS providers but only through sub-contracting by individual ambulance services.

Key findings

One of the consequences of the era of competition and markets in the NHS has been the fragmentation and privatisation of the (non-urgent) Patient Transport Service (PTS). For some patients, this has meant a poor service and there have been several very high profile examples of poor private providers. This has left NHS ambulance service organisations that traditionally provided PTS less stable and added to the fragmentation of the urgent and emergency care system.

For staff moving into the private sector, after competition for service provision, the almost universal outcome has been negative. In a survey conducted by UNISON of staff working in PTS, only 4% believed privatisation had delivered any benefits for patients.

Whilst the CQC regulates PTS providers, and there are almost 300 organisations registered, the inspection regime is not seen as robust and does little beyond basic checks. Terminations of services and contract closures have been due to public, political and trade union pressure on commissioners not regulatory intervention.

With the publication of the Five Year Forward View[2] in 2014, and the development of the 44 Sustainability and Transformation Plans[3], we are now in an era where collaboration and cooperation are more important and where planning on a geographical basis for a care system is coming back into fashion. It is an obvious time to look again at provision of patient transport services.

Similar issues have been raised around the fragmentation of services, unexplained variation in outcomes and weakness of commissioning of the emergency provision of ambulance services; and, as reported to the Public Accounts Committee on 20 March 2017, there will soon be a national operating model and a national approach to commissioning the service.

Patient Transport

It has always been part of the NHS offer that for some patients, based on need, transport to an acute setting is free. This applies to a 999 call, but also routine transport to and from an outpatient appointment or discharge following a hospital stay. In the early 1970s when the ambulance services moved into the NHS they were regarded as transport providers – quick scoop and drop to A&E and a slow journey to outpatients or to home.

There have always been a few private providers of non-urgent patient transport and some hospitals have their own transport service. However, until the era of markets the service was predominantly provided by ambulance services alongside, and loosely attached to, the blue light 999 service.

Ambulance Services

Over the years, ambulance services have changed dramatically and are now an integral part of the NHS, providing far more than transport. We now have highly skilled paramedics, technicians and emergency care practitioners able to provide care and preventing unnecessary admissions to hospital. It is now possible to see ambulance services more as the integrators of the pre-hospital urgent and emergency care system. Transporting patients to the right setting remains a vital part of the role, but now ambulance staff have the ability to make decisions about which setting would be most appropriate.

[2] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[3] https://www.england.nhs.uk/stps/

Ambulance services have become very good at assessing risk, managing flow, allocating resources effectively in real time, and balancing variable demand. The majority of their funding for providing the emergency care is provided on a per capita basis.

The role and importance of ambulance services greatly increased early this century and the 10 current ambulance service Trusts (including NHS Foundation Trusts) are significant major NHS bodies. However, there remains resistance from parts of the NHS to accept that the services are an integral part of the healthcare system rather than a transport service. Opportunities for a more strategic role for the services are not being exploited. This is visible even today as the Sustainability and Transformation Planning process, based on 44 footprints, is dislocated from the 10 ambulance service areas. There is little evidence of a strong voice for the services in the plans. Ambulance trusts are large geographical organisations but still comparatively small and therefore lacking influence compared to the larger acute trusts.

Policy Abundance

There have been many initiatives and policies over the last two decades looking at better models for urgent and emergency care. The reality is that various policies around GP Out of Hours, NHS Direct, NHS 111 together with the opening of minor injuries units, walk in centres and urgent care centres have made the system more fragmented. The era of markets and competition has seen a proliferation of providers and a weakening of system leadership, meaning poor accountability and governance. The most recent policy guidance from November 2016 still assumes the old model where commissioners take the lead in developing better solutions through contracting – a model that is deeply flawed and which is largely ignored in the STP approach.

Alternative approach

Some commissioners have begun to explore better approaches but struggle within a system where the policy background is incoherent and the legal framework is a barrier to sensible solutions.

A better solution follows the STP direction with one lead provider of all patient transport services for each STP footprint (as with one lead provider of the NHS 999 services) – which can arguable only ever be an ambulance service. The basic operating model for PTS contracts and KPIs should be set nationally after open discussions with service users and staff, as well as STP leadership.

Collaboration between ambulance services could be used to limit variation to that reasonably justified by local circumstances and so to reduce management and administration costs, simplify regulation and put commissioning onto a far more strategic footing. In this approach, PTS is part of a more joined up and integrated service for patients, which has a strong and valuable interaction with new urgent and emergency care models.

Wider Issues with Privatised Ambulance Services

On 21 March, the CQC warned all independent ambulance providers that during its inspections it found “problems with the safety” of the care offered by the providers. In a letter to independent providers the regulator said these “*might not be isolated findings*”. The CQC is concerned some providers ‘may be putting patients at risk’. The CQC has inspected 33 independent providers and issued requirement notices to 25, ordering them to improve.

The CQC has highlighted concerns common across these reports. These include:

- a lack of attention to 'fundamental safety processes' and concerns with risk governance at some providers;
- a failure to check if staff have had Disclosure and Barring Service background checks or have the correct driving licence for their role;
- problems with the cleanliness and maintenance of vehicles and equipment, along with inappropriate medicine storage;
- poor incident reporting, with staff not always recognising safeguarding concerns; and
- patients often finding it difficult to make a complaint and failure to learn from complaints

This evidence adds to the concerns raised by staff and also reported in the media as set out in this report.

Survey

In order to explore the consequences of outsourcing PTS a survey was undertaken of all UNISON members who work, or had worked, in PTS.

One of the consequences of privatisation of PTS is that we can no longer obtain proper statistics and so we can only guess at the total number employed. Similarly, without national standards and KPIs we cannot tell if the overall is trend for an improving or deteriorating service.

It is acknowledged that whilst the number of responses is significant they were self-selecting and clearly those who were dissatisfied or had experienced difficulties were far more likely to respond. However, there is still ample evidence that many staff experienced poor treatment and witnessed poor service to patients despite their best efforts.

The questionnaire used is set out in Appendix E.

Survey Results

The sample size was 150; of these 14% worked in both PTS and the 999 emergency services. 5% worked both for a private company and for an NHS ambulance service.

Almost all of those who responded added free text in response to questions about working conditions and patient safety comparing NHS with private sector providers.

82% said that services were better or the same for patients when provided by the NHS compared to private sector providers; 5% thought private was better.

Asked to rate patient safety, 62% said it was better in the NHS whilst only 6% said it was better in the private sector.

In terms of impact: -

	Better within NHS	Worse within NHS
Pay	59%	4%
Pensions	52%	4%
Overall working conditions	75%	6%
Training	76%	6%
Equipment	72%	6%

The conditions, training and equipment high scores were consistent with the free responses.

Responses from Free Text Section of Survey

The majority of comments directly or indirectly compare a culture of profit with a culture of caring, while others make the point that private companies operate in a different environment – one which most NHS staff do not feel comfortable with. See appendix A for quotes from the survey.

There were many examples of poor patient service, some specific and some more general. The pattern appears to support the general view that there are two categories of private providers in the PTS market.

The first is a small number of larger companies, accepted as being reputable, working with their staff and accepting or improving on terms and conditions. They have now exited the market as they cannot make enough profit.

The second are smaller companies that are less reputable (which has led to the long list of complaints from the survey respondents and some of the companies receiving adverse media coverage).

The second category includes those that have either been forced out by commissioner action or else withdrawn. The worrying factor is that there remain a significant number of companies that exhibit most of the negative attributes but which still bid for and win contracts.

Background

The headline from the Guardian (12 April 2016) sums up the situation.

> ***Ambulance privatisation descends into 'total shambles'***
>
> *Hundreds of patients including people with cancer and kidney failure have missed important appointments for treatment because ambulances did not arrive to take them to hospital, after privatisation of NHS non-urgent transport services in Sussex this month.*
>
> *Some elderly patients have had to wait more than five hours for ambulances and been stuck at hospital for long periods after their appointments because the transport service, now run by the private firm Coperforma, has proved so unreliable.*

This is not an isolated incident, as we will show from similar headlines in other parts of the country.

Privatisation has had a detrimental impact on patients and staff, with reports of staff who were moved to private organisations and denied the terms and conditions appropriate for their role.

There is a basic issue about the wisdom of privatising patient services - one discussed across many different parts of the care system; for example, the very recent criticisms about the debacle of Capita taking over Primary Care Support services. A recent study into the

impact of privatisation of hospital cleaning services showed that outsourcing the work had led to cost savings but also to deterioration in quality[4].

Privatisation is always a difficult issue but the general rules for making any service subject to competition is that the requirements can be fully defined (and put into a contract); there are many willing suppliers (so genuine competition) and that any failure of the contract will not impact adversely on other parts of the system (risk of failure is manageable). With PTS, the experience has shown effective contracts to be illusory; there are many providers but this implies tiny organisations with no NHS background can be part of a contracting relationship and the third condition is simply not met.

However, there is also a deeper issue about the role of ambulance services generally and how to bring back some kind of joined up emergency and urgent care services. Rather than seeing PTS as some separate add on it should be an integral part of an ambulance service, which is itself the foundation of the urgent and emergency care system for any locality.

A further strategic issue is the role of commissioning. With the advent of STPs it is becoming obvious that the latest incarnation of commissioning with 200 CCGs (after PCO, PCT, larger PCT, clustered PCT) has adverse affects. It would be far better, less complex and cheaper to commission all patient transport (emergency, urgent and non-urgent) on a much wider population basis – with national standards, contracts and KPIs (with some permitted local variation).

Ambulance services could hold the contract but would be able to sub-contract, as required by demand, making governance and accountability far clearer and regulation easier and more effective. It would also allow for better joined up urgent and emergency care as is being advocated in Transforming Urgent and Emergency Care Services[5] in England and help to enable the various new models of care described in the Five Year Forward View to be implemented especially in supporting the drive for care closer to home.

Reported Issues with Privatised PTS

Coperforma Saga

Perhaps the worst example of PTS contracting was in Sussex. It is worth looking at in some detail as it demonstrates a combination of most of the factors that had been experienced but to a lesser extent in many other examples.

Ambulance privatisation descends into 'total shambles' - Guardian 12 April 2016[6]

Any internet search into patient transport rapidly throws up numerous references to the scandalous failures in Sussex involving the private provider Coperforma. NHS High Weald Lewes Havens CCG, acting on behalf of seven CCGs in Sussex, led the procurement process. They remain as the lead commissioners for PTS in Sussex. The contract

[4] Researchers from the University of Oxford, the London School of Economics and Political Science, and the London School of Hygiene and Tropical Medicine have undertaken a study of 126 English NHS Trusts comparing the rates of MRSA in those that provide in house cleaning services versus those who outsource. The research has found that the occurrence of MRSA is almost 50% higher in NHS Trusts that use outsourced cleaning services.

[5] https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

[6] https://www.theguardian.com/society/2016/apr/12/patients-wait-hours-for-ambulances-nhs-transport-service-privatised-sussex

commenced on 1 April 2016, a date with some irony attached. From 1 April 2017, South Central Ambulance Service NHS Foundation Trust will provide the service with the costs stemming from the contract failure not yet disclosed.

Within weeks of the start of the contract, numerous complaints led to an independent investigation by business assurance specialists TIAA. Their report – '*NHS High Weald Lewes Havens Clinical Commissioning Group; Adequacy of the mobilisation arrangements for the new Patient Transport Service contract*[7]' is brief but informative.

The TIAA report is fairly strong in its criticism of the contracting process (which lacked relevant expertise) and of the contract mobilisation and makes clear that this indicates possible longer-term issues, although it does accept that some improvements were being made. Further examination shows a naive approach and a total failure in commissioning at every stage. Although FoI requests have been made, it is unclear if any of those responsible for the debacle were ever brought to account or what lessons have been learned.

Whilst on a smaller scale this saga has many common elements with the collapse of the much bigger contract in Cambridge and Peterborough involving Uniting Care. This led to major investigations, including by the National Audit Office and the Public Accounts Committee. Beyond technical factors, both these examples show failures in commissioning – initial claims that using a contracting process and outsourcing will lead to benefits being comprehensively demonstrated, turned out to be illusory.

Reality contradicts with the information on the web sites of the Sussex CCGs from the time. These are confident and positive up to the point where there is an acknowledgement of failings then the announcements that the contract will be ended – not terminated.

Whilst perhaps an extreme example it is a clear demonstration that commissioning of this kind is far harder than assumed and can easily fail. This implies that the risks associated with going down a procurement route must be factored into decision making.

Even the lead commissioner had to reluctantly accept that there were serious issues as set out on their web site: -

> *Since 1st April 2016, the Sussex PTS has been managed by Coperforma; which took over the contract following a competitive procurement and tendering process. The start of the new contract saw unacceptable levels of performance, both in making bookings and with the transport itself. Patients and health professionals had difficulty getting through on the phone lines and many patients were collected late or not at all.*
>
> *Performance has improved, although the improvements are not consistent across the whole of Sussex and some patients continue to experience problems. Recently, there have been a number of issues between Coperforma and some of its subcontractors, which have raised concerns about the sustainability of the service. In September, the CCGs stepped in to pay staff of Dockland Medical Services after the company stopped providing the patient transport service for Sussex patients.*
>
> *Now Coperforma has agreed to step down from the contract. In order to minimise disruption to patients, the transfer will be phased over the next few months, with SCAS taking complete responsibility from April 2017. Patients do not have to do anything. They should continue to book their transport as they normally do. Gradually, more and more of the service will be taken over by SCAS.*

[7] https://www.huwmerriman.org.uk/sites/www.huwmerriman.org.uk/files/2016-08/Sussex%20CCGs-Patient%20Transport%20Service-f.pdf

> *Wendy Carberry, Chief Executive of High Weald Lewes Havens Clinical Commissioning Group, which manages the contract on behalf of the seven Sussex CCGs, said:* "We are delighted that SCAS has agreed to take over the patient transport service. The managed transfer will minimise disruption for patients. And we can start to resolve the situation for staff who have been through a period of uncertainty."

None of this in any way shows acceptance of the huge distress and harm caused to patients and to staff due to this botched privatisation. Speaking to some of the staff involved is harrowing. Some with many years of NHS experience having high levels of job satisfaction and pride in their work were reduced to tears by how they were treated. There are well documented reports that staff went unpaid and that this led to more than just "a period of uncertainty" – it led to great stress; one staff member losing their residence as they could not meet payments.

The management of staff was beyond amateur with no proper HR function and a lack of understanding of the implications of the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE). Attempts were also made to undermine established terms and conditions that should have been protected by TUPE. Staff were bullied by aggressive managers and had no obvious recourse through any proper procedures or processes.

Some staff did not get proper uniforms, and some simply carried on wearing their NHS kit. Those given charge cards for fuel found that on occasion they did not work and so had to pay for fuel themselves. Vehicles were often in poor repair or inappropriate for the patient need. Some staff resigned in despair losing considerable pension rights as a result. One member of staff was assaulted by a bailiff trying to repossess a vehicle that was supposed to be being used to take patients to hospital.

Not only were patients and staff affected by the events that took place it emerged that the main contract was just a layer and most actual work was subcontracted. The subcontractors claim that they lost large sums of money.

It is acknowledged that patients were impacted by what happened and it is clear that some patients who were entitled to free transport, and who had been previously provided with this service, were denied it as a result of the privatisation.

After the collapse of this contract, employees transferred back into the NHS. At a meeting attended by staff to hear about the transfer back into the NHS, staff likened it to being "*rescued from the titanic*".

Regulatory Issues

The Care Quality Commission (CQC) announced on 1 November 2016, that it would continue to monitor the PTS during the transition and published its full report on the service provided by Coperforma Ltd following an unannounced inspection in July 2016. The CQC told the company that it must sustain significant improvements to the service in Sussex and served six requirement notices to the service to ensure improvements were undertaken. A full report of this inspection has been published on the CQC website[8].

Areas for improvement included:

[8] http://www.cqc.org.uk/sites/default/files/new_reports/AAAF9079.pdf

- *The provider must ensure a robust system is in place for handling, managing and monitoring complaints and concerns.*
- *There must be robust systems in place to assess, monitor and improve the quality and safety of the services provided.*
- *The vehicles and equipment used by contracted services must be appropriate for safe transportation of patients, including wheelchair users*
- *Patients must receive timely transport services so they can access the health services they need from other providers.*
- *A manager must be registered with the Commission.*
- *CQC must be notified of safeguarding incidents and incidents affecting the running of the service.*

These findings, so soon after the contract started, shows just how poor due diligence over the contract award must have been.

Of passing interest is that one of the companies that was part of the contract in Sussex (though not the prime contractor), Thames Ambulance Service, a company specialising in patient transport, has been awarded a five-year contract worth £5 million in Lincolnshire. It will provide non-emergency patient transport across the county from 1 July 2017 operating from its new site at the Pelham Centre in Lincoln, after being handed the contract by Lincolnshire West CCG.

Questions have been raised about whether in agreeing the contract the commissioners in Lincolnshire took into account the lessons learned in Sussex.

NSL

NSL entered the PTS market when it opened up around 2013 having become successful in other sectors. It has now left the market. The company had problems with its contracts in Northamptonshire and Kent. However, the issues around its contract in the South West provide a different lesson to that from Coperforma and Sussex.

The issues identified, and the reports from the CQC show, that whilst staff were generally well treated and that patients reported good service the provider struggled all along to meet the requirements that this kind of public service demands. In the end, it is obvious that a quality service provided by well-motivated, fairly paid staff is inconsistent with the pricing framework adopted by commissioners.

NSL was subject to repeated inspections by the CQC including a final comprehensive inspection in 2016 that was used as a pilot for better inspection of PTS generally.

The CQC report from November 2015 set out some history: -

> *At the time of our inspection NSL South West Region had given notice to terminate each of its three contracts in April to September 2016 and was in the process of re-tendering for the Devon contract and intended to re-tender for the Somerset and Cornwall contracts in 2016. NSL South West Region were continuing to provide a service to the three commissioners until April to September 2016. We inspected the service in November 2013 and were concerned about patients arriving late for their appointments, staff recruitment practices and the safety of their vehicles.*

We re-inspected the service in June 2014 and were concerned about the lack of consistency of training provided to new staff as opposed to staff that had transferred over.

We were also concerned that action was not taken over vehicle defects. We told the provider of the actions it needed to take and monitored these actions at a follow up inspection in December 2014. During this inspection we found the provider had improved its recruitment practices.

We re-inspected the service again in February 2015 and found the provider had made significant improvements in their performance. We also found concerns that the provider did not have robust systems in place to provide assurance that people's needs were met and that risks to staff and people were identified and addressed. At each of our inspections, we found the staff to be very caring towards their patients, and this was reflected in the positive comments received from patients about the staff.

This shows that oversight by commissioners must have been poor, that the contracts specification was not appropriate and that the prices offered and accepted were unrealistic.

A company such as NSL appears to have tried its best but could not deliver. Strong indication, yet again, that commissioning through small CCGs just is not an appropriate methodology within a complex and dynamic system, such as the NHS.

Other Examples

It is easy to find media coverage of other examples of where privatisation of PTS has led to problems. This does not mean that every privatised service is poor, as there are some PTS providers that have delivered services without issues for many years. It is also true that there have been far fewer reported issues with public sector provided PTS as for example in Scotland and Wales – although these reports show issues from the general NHS problem of inadequate funding rather than a problem with "contracting".

There is more than enough anecdotal evidence to show that the recent drive towards privatisation, where private providers contract directly with commissioners, as opposed to being sub-contracted, has led to problems. Some issues may rest with commissioners because of poor contracting, but it cannot be denied that some changes were based on cost cutting and have led to poor service.

Below are examples taken directly from the mainstream media.

Troubled private ambulance transport service [NSL Ltd will not bid for new contract in Northamptonshire - Northamptonshire Telegraph 18 November 20159

Hundreds of complaints after company [Arriva Transport Solutions Ltd (ATSL)] fails to get patients to appointments on time – Gloucestershire Live 6 March 201510

[9] http://www.northantstelegraph.co.uk/news/troubled-private-ambulance-transport-service-will-not-bid-for-new-contract-in-northamptonshire-1-7070854

Bus firm running non-emergency patient transport [Arriva Transport Solutions Ltd (ATSL)] pays back £1.5m after standards reporting gaffe – Mirror 3 November 201511

Arriva transport criticised for keeping patients waiting up to four hours – BBC Nottingham 9 April 2015[12]

Private firm [Arriva Transport Solutions Ltd (ATSL)] ditched as North West Ambulance Service wins back Patient Transport Service – Salford News 15 December 2014[13]

DORSET'S patient transfer service [E-zec] is still failing to meet its targets, has gone £2m over expected budget- and more than 13,000 journeys have been aborted in the last year – Bournemouth Daily Echo 25 May 2015[14]

NHS horror: Heart-attack victims forced to wait FOUR hours for ambulances [ERS Medical] – Sunday Express 18 August 2014[15]

Drivers at ambulance firm ERS Medical demand urgent action to prevent failings in Mid-Essex – Essex Chronicle 28 July 2015[16]

Criticised ambulance firm NSL Kent withdraws bid – BBC News Kent 11 November 2015[17]

New non-emergency ambulance service [Thames UK] 'sorry' for chaos – Grimsby Telegraph 7 October 2016[18]

PTS Landscape

Before the creation of CCGs and the Health and Social Care Act 2012 the provision of PTS was mostly by ambulance services. After the recent years of competition and privatisation this has reduced so that around half of PTS remains in the public sector.

There were numerous small organisations pre-2013 that had contracts with single NHS Trusts or clinics or provided services sub-contracted to them by the main provider. These well-established providers do not appear to have caused any significant issues.

---

[10] http://www.gloucestershirelive.co.uk/hundreds-complaints-company-fails-patients/story-26130348-detail/story.html
[11] http://www.mirror.co.uk/news/uk-news/bus-firm-running-non-emergency-6754569
[12] http://www.bbc.co.uk/news/uk-england-nottinghamshire-32231145
[13] http://salfordonline.com/14943-ambulance-service-wins-back-patient-transport-from-arriva.html
[14] http://www.bournemouthecho.co.uk/news/12969568.Complaints_against_Dorset_patient_transfer_service_E_zec_expected_to_rise_after_13_000_journeys_aborted_in_the_last_year/
[15] http://www.express.co.uk/news/uk/500868/NHS-ambulance-scandal-as-heart-attack-victims-forced-to-wait-up-to-four-hours
[16] http://www.essexlive.news/drivers-ambulance-firm-ers-medical-demand-urgent/story-27462410-detail/story.html
[17] http://www.bbc.co.uk/news/uk-england-kent-34791457
[18] http://www.grimsbytelegraph.co.uk/new-non-emergency-ambulance-service-sorry-for-chaos/story-29784377-detail/story.html

Post 2013 there were new entrants into the market. The evidence suggests that some were established organisations already operating in different or related sectors that saw an opportunity. Mostly these organisations were reasonable employers who tried to provide decent services – but failed. The rest were new entrants who lacked relevant expertise and have caused major issues for staff and patients and other parts of the NHS.

Sadly, lessons around poor commissioning decisions have yet to be learned and outsourcing and privatisation is continuing, at least in some parts of England.

Commissioners of PTS

Many CCGs believe, or have been advised that, NHS services must be put out to competitive tender due to the H&SC Act 2012 S75 Regulations[19] and the wider Public Contracts Regulations 2015.

In very simple terms these regulations, which are binding on NHS bodies, require any contract being offered to be put out to competitive tender in line with the Regulations. Exceptions do apply, for example, where it is clear that there is only one realistic supplier, but for PTS service, as defined by commissioners, there is a strong argument that says tendering is necessary.

This approach of defining the NHS in terms of a set of separate services that can be separately defined and thus contracted for is hopefully now being abandoned in favour of the more collaborative STPs. If it continues, however, it will have a progressively more and more damaging impact on ambulance services. It could mean everything other than the blue light response being contracted out – each bit being seen as separate. Control room functions could be outsourced and run by a private company and urgent but non-emergency responses hived off to a multitude of separate providers. Who provides the transport for non-emergencies would be a matter for open competition.

This fragmentation has indeed already been seen with tendering for NHS 111 and GP out-of-hours services. There are also related lessons from the collapse and demise of NHS Direct. Again, commissioners had unrealistic expectations; agreed poor contracts and the results were poor. Hopefully, as part of an integrated urgent and emergency care system NHS 111 services will return, with ambulance services acing as integrator and main provider.

Issues for Commissioners

One of the key problems with the current commissioning approach is that it fails to look at the impact or cost across the whole system. This is a known issue with other developments such as attempts to invest in out of hospital services to reduce demand for A&E. As with many such cases, whilst commissioners may have a case for saving money the whole system cost increases as fixed costs cannot easily be reduced.

Commissioners may argue that they have secured the required PTS service at a lower cost than could be offered by the incumbent ambulance service, but removing the contract from the ambulance service has financial consequences to the wider NHS. One example is where the loss of PTS contracts left an ambulance service with redundant assets of well

[19] These are provided in Appendix B. In simple terms the guidance issued in respect of S75 presents three exemptions to competitive tendering: where there is only one provider capable of providing the service; where a detailed review of the service provision in the region identifies the most capable provider or providers of those services; and where the benefits of competitive tendering would be outweighed by the costs of publishing a contract notice and/or running a competitive tender process.

over £1m. There is also the cost of taking part in tendering exercises – one ambulance service reported that it had spent approximately £1.3m in a year on this but had not secured a single contract.

Allowance for risk also has to be a further part of the whole system costs. As the report sets out, there have been a number of clear examples of where contracts have failed and in such cases, due to its overriding duty to patients, the NHS picks up all the cost of recovery. This risk needs to be priced into the contracting process. It sits with the approach of "optimism bias" which was introduced in the public procurement process (particularly in respect of PFI) to adjust for risk.

It is not enough to use only cost and quality to compare provision of a service. Risk has to be a factor when looking at the price of public or private provision. Despite the history of failed PTS contracts, and the wider whole system costs of poor or failed contracts, there is no evidence from the procurement documents that have been examined that this approach is used.

A Different Approach

One way to avoid the pitfalls of enforced tendering might be to define requirements in a far better way. Although there is a risk of legal challenge on the grounds of anti-competitive behaviour, collaboration between PTS service providers for a more common approach, to share ideas and best practice would develop better models of care. Commissioners, service users and providers could design and deliver services in a more coherent way.

Impact of Privatisation of PTS

First, it is reasonable to ask if any benefits have resulted from CCGs privatising PTS. There is no doubt that pre-2013 there were some issues with traditional PTS. Commissioners would be justified, indeed that was their role, to look for improvements. Some commissioners and some PTS managers will accept that the era of competition did require some new thinking by ambulance service providers and as a result there have been improvements both in quality of service and in value for money. This idea of an external challenge leading to improvement cannot be easily dismissed.

However, the innovation was within the ambulance service providers, it was not that the private providers brought innovation to the system, which suggests better management rather than privatisation could also have achieved valuable changes.

Many people claim that CCGs use competition and tendering simply to drive down cost within contracts. More recently, the requirements around quality of service in contracts have become more significant (one manager suggested 60% quality, 40% price now the norm). However, as media reports show, costs have been driven down and in some cases significantly – once again very reminiscent of the early days of NHS 111. Some contracts were set at unrealistically low cost levels and collapsed. Some contracts rapidly required top up payments and subsidies – although getting information about this into the public domain is not straightforward.

One outcome is that ambulance services have had to look very critically at their own operations to improve service delivery and reduce costs – as most services acknowledge in their published reports and plans.

Staff view – the transfer experience

Evidence strongly suggests that almost all staff transfer to the private sector reluctantly and soon miss the NHS ethos while staff with many years' experience leave in despair at their treatment by new employers. Some staff go without pay for significant periods, some have monies taken from their remuneration illegally and new entrants into the new providers are disadvantaged in terms of pay and conditions.

New employers have poor HR functions (if any) and do not understand their requirements under TUPE regulations. Attempts are made to vary terms and conditions by imposition and not through proper bargaining. Private providers simply lack appropriate governance and reporting systems – such as those built up in the NHS over many years with many staff reporting bullying and other unacceptable practices. Staff find communication with their controllers impossible and systems used to plan journeys are poor and expectations unrealistic.

Patient view – the transfer experience

Some patients are denied transport that they are entitled to, some failing to make appointments due to transport failures and some experiencing prolonged waits with little or no information.

Arguments over contracts replace a more general can do attitude – contracts fail to be detailed enough so many cases lead to arguments. Disputes between PTS provider, ambulance service and hospitals proliferate with some taking hours of argument to resolve who has responsibility for moving a single patient and fragmentation of the PTS means attempts to integrate services are harder.

System view – the transfer experience

Private providers have no real strategy or plan for service development so play little or no part in looking at system wide issues. Poor systems for data collection mean valuable insights into patient flows are missed.

Poor PTS delivery adds strain and extra cost to the 999 service and extensive sub-contracting reduces effective control and weakens governance whilst gaps in service provision soon become evident after contract signing (in one case a whole geographical area was missed out altogether) suggesting flawed procurement.

This strongly suggests that the costs of privatisation far outweigh the benefits. It also strongly suggests that the method of commissioning by CCGs (or groups of CCGs) adds an additional and unnecessary cost with huge duplication of administration and management functions.

Current PTS Provision

At the time of writing, there are four PTS contracts at various stages of tendering. It is possible in most cases to access the procurement documentation. This unfortunately does not show that lessons have been learned.

The tension between the STP approach and what UNISON and others regard as the absurdity of the H&SC Act is well documented but mostly ignored.

Sadly, there remain parts of the country and particular CCGs that have not yet got the message and who are still obsessed with competition and tendering. Again, due to the H&SC Act the autonomy of the CCGs and the complete lack of any strategic oversight little can be done to prevent the damage that has taken place previously, from reoccurring.

The analysis shows serious cause for concern simply at the level of service delivery. But there are also more strategic issues to explore. What are the future intentions of the ambulance services with PTS? Do commissioners of PTS acknowledge past problems? Are the current plans (STPs) taking patient transport issues into account and are these plans taking the lessons of failed privatisation of services into account? Do the STPs acknowledge sufficiently the opportunities offered by developing ambulance services (including PTS) as a strategic integrator?

Through FoI requests, the 10 ambulance services in England were asked in which parts of their "area" they provided the PTS service and if they had lost any contracts to provide PTS in the last 5 years.

The picture shows a north south divide in that most PTS in the North is, and always has been, provided by the ambulance service. One contract (for Cheshire) was lost to another ambulance service and only one small contract (in Hull) lost to a private provider.

Elsewhere the picture is different and in East Midlands and the South West there is almost no delivery of PTS by ambulance services. London has always made use of multiple private providers and is still the most fragmented area in terms of providers. East of England, South East Coast and South West have all lost significant contracts to private providers.

Commissioners' Intentions

The system has already moved significantly towards PTS being commissioned through CCGs rather than through individual trusts. This is more of a locality based approach and is in line with general direction of STPs, but still leaves many small contracts with small CCGs. There is no national template or KPIs yet for PTS contracts and there are still some Trusts providing their own transport or having their own contract(s).

Of interest is - *Developing an ambulance commissioning strategy: Five Year Forward View and beyond - from the National Ambulance Commissioners Network* published in November 2015[20].

Some of the recommendations in this report are relevant: -

- *There should be a refocus on commissioning and provider systems that support non-conveyance and provision of the right care closer to home as its principal aim for most patients, while continuing to provide immediate transport and treatment solutions for those emergency patients who need a fast response.*
- *We need a focus on an improved triage that will be consistent, systematic and focused on the right response for the patient (based on patient outcomes and appropriate speed of response).*
- *There is a need to develop a workforce and training plan with commissioners to support the shift to new models of care which are realistic in terms of timescales for implementation and address geographical differences.*

[20] https://www.nhscc.org/latest-news/ambulance-commissioning-strategy-5yfv/

- *Collaboration is fundamental in developing new models of care through a multiplicity of collaborative forms including sub-contracting, alliance and prime providers.*

The following direct extracts from the report are also relevant.

> *Transport model*
>
> ***Currently there are two levels of transport recognised across the system – urgent and emergency, and patient transport service (PTS). Within each area there are also differences around the protocols or criteria to access transport, and a range of providers. With the evolving care models and the drive for more care to be delivered closer to home, there is a need to review the current model with the potential to have different tiers. This could include unplanned, planned and enhanced PTS, which is an intermediate tier within the urgent and emergency care setting.***
>
> *Enhanced PTS and intermediate tier*
>
> *This new transport tier would provide a timed response, (within a set timeframe) for those patients currently classified as 'urgent' who require transport to hospital with the support of staff educated to a designated level.*
>
> *This group of patients are usually 'booked' between the hours of midday and late afternoon following assessment by a GP or other healthcare professional, and require transport to the emergency department. Depending on demand across the system, these patients can wait for long periods of time, which could result in the categorisation being 'upgraded' requiring an eight-minute response. It can also create 'batching' at the emergency department, thus putting even further pressure on the system.*
>
> *To achieve an alternative transport model at the pace required and maximise the use of current transport methods, commissioners and providers need to work with other partners or providers to develop partnerships and subcontract.*

This shows that commissioning intentions may be moving towards a better model where transporting patients fits into a wider more integrated care model. In such a model, there may be opportunities for private transport providers but only as "sub-contractors" to what will inevitably be an ambulance service that is the principal integrator.

Strategic Intentions of Ambulance Services for PTS

It is easy to view a variety of documents, annual reports, five-year strategies and integrated business plans from the 10 English Ambulance services. All mention PTS and most see providing this service as part of their possible range of activities. Some see this as a business opportunity and express concerns about the ability to win contracts in a competitive environment. Some clearly see PTS in a wider strategy more in line with the views of the Association of Ambulance Chief Executives – *A vision for the ambulance service: '2020 and beyond' and the steps to its realisation*[21]

[21] http://aace.org.uk/wp-content/uploads/2015/09/Ambulance-2020-and-beyond-the-AACE-vision.pdf

London appears agnostic to being a PTS provider and South East and South West appear to wish to exit from provision altogether. The northern services all have a history of being the major provider in their area and see this role continuing.

Some examples from recent documents: -

East of England Ambulance Service (EEAS) appear to have least well developed plans. They have lost several PTS contracts recently. On the other hand, they recently won a contract with commissioners in NE Essex – taking over six previous contracts. In its Annual Report 15/16, a section on PTS says: -

> *Contracts for patient transport services are tendered by CCGs and so patient transport services operate in a very competitive market with many private companies bidding aggressively for the business. However, we do believe the Trust is best placed to deliver patient transport services, with dedicated, committed and passionate staff. The PTS service also complements our 999 emergency services and our resilience teams in the event of a major incident.*

It is unclear how EEAS see PTS within the overall service delivery model or what their commercial intentions might be.

East Midlands Ambulance Service (EMAS) appear to have provided little documentation of relevance and they have also lost all but one contract in their area. However, their most recent Annual Report does state, "*Won the contract for Derbyshire from 1/4/16 and will continue to pursue other PTS contracts*"

London Ambulance Service (LAS) have never been seen as a major PTS provider and provision across London has always been fragmented. In its five-year strategy 14/15 to 19/20 there is a planning assumption – "*we will lose PTS services*". This does not appear to raise concerns, nor are issues around wider integration of services including PTS addressed. London is always regarded, and regards itself, as a "special" case.

North East Ambulance Service (NEAS) have seen a big increase in PTS journeys but sees this being reduced as new care models develop. They set out proposed reconfiguration of its resources, including PTS, which they see as moving to a more patient friendly appointment based system. This shows strong support for retaining its PTS role across its area.

North West Ambulance Service (NWAS) have a lengthy section in its 5 Year Plan on PTS. It sees patient transport on a wider model as part of the drive towards "*safe care closer to home*". It is developing a PTS Patients Charter and has ongoing engagement with staff and patients; other developments of its service are planned. This again shows a strong commitment to PTS within the ambulance service role.

South Central Ambulance Service's (SCAS) 5-Year Strategy sees PTS as a commercial opportunity that it could grow. They also sees developments with closer working and resource sharing across PTS, 999 and 111. They have recently stepped in to take over the failed Sussex contract and could potentially be a strong contender to mop up contracts in the south as the two other services are withdrawing from PTS.

South East Coast Ambulance Service's (SECAM) Strategic Plan 14/19 has PTS market as an opportunity but also sees current provision at risk. It acknowledges recruitment and retention issues with PTS and does reflect that PTS services must be "financially sustainable". Its overall objective to "*expand our services in urgent unscheduled care through prime and alliance contracting*" fits better into the commercial rather than the

integration model. They would have liked to remain a PTS provider but had to do a lot better to keep and win contracts. More recent developments with lost contracts appears to indicate the intention is not to be a serious player in the PTS market.

South West Ambulance Service (SWAST) appears to be withdrawing completely from PTS provision as it states in its Integrated Business Plan 14/15 to 18/19: -

> "*Following numerous tendering activities it was confirmed to the Trust in Quarter 1 of 2013/14 that all of its PTS contracts, with the exception of the BNSSG area and the Isles of Scilly, had been awarded to private providers."*

It is understood that the contract for BNSSG has also been lost.

West Midland Ambulance Service (WMAS) wishes remain in the PTS "market" and they have a well developed Business Plan to underpin this objective. Discussion with key managers at WMAS as well as viewing public documents confirms this intention. They recently won a contract for PTS out of area. They are also clear in developing new models for care in which all forms of transport including PTS in a modified form, contribute to the aim of getting the right care for patients.

An interesting development in their area is with the cross Birmingham contract which is innovative and a sensible move in the direction of better integration. The multi-million pound contract means the Trust will complete about 160,000 patient journeys a year to New Cross and Russells Hall Hospitals as well as a number of other venues. The contract is for 3 years with an option of a further 2 years.

The contact, which was awarded after a competitive tender, means WMAS now provides transport for over one million patient journeys a year across PTS contracts. WMAS has taken over the contract from NSL Limited. WMAS has worked closely with Dudley and Wolverhampton CCGs to develop a service that will deliver a range of improvements for patients.

The Yorkshire Ambulance Service (YAS) – has a Strategic Plan for PTS which expired in 2013 but which showed a clear intent to stay as the dominant provider in its area. In its Integrated Business Plan 14/15 to 18/19 there are many positive references to PTS.

Association of Ambulance Services Chief Executives Position

AACE has produced a short but important document - A vision for the ambulance service: '2020 and beyond' and the steps to its realisation - dated November 2015. It links very much to the 5 Year Forward View but not to the STPs.

Given its strategic nature it is very clear on an integrated collaborative service model but it does not explicitly refer to PTS as it would no longer be viewed as something separate to be tendered out and competed for.

It also addresses a key point in this report which is the missed opportunities to involve ambulance services far better in developing new models of care; moving away from the traditional, one-dimensional view of the ambulance service and promoting the ambulance sector as a coordinator of clinical and social responses and a mobile healthcare provider, operating in a range of settings, employing advanced clinicians to manage more patients at home.

Ambulance Services and PTS in Sustainability and Transformation Plans

A statement on behalf of AACE is clear in showing that there could and should be a strong role for ambulance services within the process of transformation of care models as within the 44 STPs.

"*AACE remain absolutely committed to the STP process and is confident the Ambulance sector has much more to offer to ensure the NHS continues to provide cost effective and efficient health care services to our patients*"

Appendix A

Quotes from Survey Responses

A selection of quotes follows. These have been edited only for major typing errors or to remove identifying comments.

The base was a portacabin in a car park with no running water, outside toilets with no light or heating, staff were provided with cold bottled water to drink - which they then had to use to wash their hands when they'd been to the loo (!), chairs from a local school because there had been insufficient seating, the access was a single 10" step that was more of a trip hazard with no hand rails, the cabin was at the back of the parking lot and there was inadequate lighting and there were insufficient resources for the crews to clean and restock their vehicles. We managed to get them to move early to a proposed new base and HR wrote and informed me they now had warm running water (as if it was a miracle!).

> *Not enough vehicles or staff because the criteria change for the patients we take a lot more patients who really don't need transport the hospitals let us down by saying patients are ready but when we arrive the patients aren't or they book the wrong vehicles which is a waste of time for us crews and frustrating for the patients. We have a 15-minute waiting rule for wards but we constantly get ignore by nurses, with the hospitals in XXX are all on black bed status it affects patients by being discharge when they are not fit to go home or don't have the care package in place for them*

Patients subjected to rigorous screening questions when attempting to book transport, many are obviously elderly and vulnerable, both newcomers and regular PTS patients have been refused transport and have been left extremely distressed and confused. Patients not picked up for appointments or late for appointments, some of these appointments have been urgent and on a time slot and have consequently had to be rescheduled Patients left waiting for hours after appointments for their return transport, on more than one occasion found upset and in tears.

> *Driver training of staff not to the same standard of the NHS. Laundry was integrated within the NHS Hospitals and Ambulance Service, if a patient becomes cold no blankets are now available.*

Inferior equipment than that used by the NHS. The system in place within the NHS meant patients had regular drivers that they got to know and built up a relationship with. This helped them feel more at ease and gave reassurance.

> *Patients have experienced difficulties when booking transport when they clearly qualify resulting in very anxious and upset patients. I feel that staff training is inadequate especially when performed in a staff room. Vehicles are not properly maintained. Staff not always given meal breaks.*

Training in the private sector is very poor and extremely minimal. Staff do not have even a very basic knowledge of ambulance work. Two weeks of poor first aid training and they think they're experts.

> *You definitely feel the emphasis is not on the patient. Resources are limited and patients are the end user so have to wait. Ambulance crew staff make an effort to make sure the patient goes where they are meant to on time. Higher up at control and management level this seems to vanish. Some of the inefficiencies are caused by the NHS too. Wrong bookings, hospital discharges not ready to travel all waste*

time and resources. Taking a patient 70 miles for a 15-minute appointment seems crazy.

Patient choice of which hospital to go to is too free, making demands on patient transport greater when they pick appointments out of the county. Privatisation has capped resources and investment in the service to a level that makes a return. Equipment and vehicles become stretched to the limit

Patients medical condition is not a priority for allocating journeys. Planned journeys are based on postcodes and number of seats on the ambulance. Priority information regarding patient's condition is documented in the journey notes which is not always understood by controllers who have no work experience on the road. New staff who have had minimal training are sometimes put into situations that they have no experience of or are not aware of the implications until something goes wrong.

Planning of workload by controllers is based on clearing the work for the day. Crews are pressured into working over their normal hours. Single crewed vehicles are regularly loaded with wheelchair patients which increases manual handling issues as no vehicles have tail lifts and the trend is for longer and wider ramps that increase in weight. Information passed to control about patients' needs are not always documented properly so that the next time the patient is moved additional stresses are added to the patient at times when stress levels can be high. Manual handling equipment levels supplied are minimal. Vehicles are maintained to be roadworthy but not for patient comfort or crew well-being.

The company's behaviour towards patients is terrible which includes lying to cover their failings. Vehicles do not have first aid kits. unable to give basic life support as no equipment for supplying breaths. Staff not trained with appropriate qualifications e.g. staff are given f.p.o.s (first person on scene) this is for emergency response not patient transport. No effective moving and handling. new staff have little to no idea on how to use o2 equipment what type of mask and how much to put through it potentially putting lives at risk.

Cost cutting by private firms has led to longer delays due to inefficient, understaffed booking and control rooms. Equipment not up to the same standard, putting patients at risk, for example the use of freestanding steps rather than steps that are a part of the vehicle. The use of mobile phones instead of airwaves radio means jobs cannot be passed to drivers safely whilst they are driving the vehicle.

Training at private companies is not enough; staff are not stimulated to provide a good service. The approach to the job from some of the employees is wrong. They consider this; I quote "Job that pays the bills". Having approach like this is wrong. Most of the private PTS companies are not spending enough money for their personnel. Private companies are finding various ways to drain NHS (e.g., Marking PTS ambulances as an Emergency ones, pairing crews that are not trained to provide emergency help to the general public and more). The scope is shifted to a wrong direction, money, instead of care. Of course, not all the private companies are like this, but the majority are. This is an opinion, based on personal experience!

Patients have experienced difficulties when booking transport when they clearly qualify resulting in very anxious and upset patients. I feel that staff training is inadequate especially when performed in a staff room. Vehicles are not properly maintained. Staff not always given meal breaks.

Under so much pressure to move patients. Patients are waiting hours as not enough staff. There is no patient care anymore. Private company will take anybody and not

check into risk assessment on how safe it is to move that patient. Corners are being cut. Staff not being listened to. Being told just get on with it. This causing morale at all-time low. DNAR patients have not got correct info on. So, told if not filled in correctly You have to resuscitate. Can't move a lot of patients due to many are 2 men crew needed. Weekends not enough staff. Patients waiting to go home 6 hours late, these patients could be diabetic, have carer come in to put to bed and miss their time slot.

In order to win contracts, the private companies quote so low that they cannot actually provide the service as contracted. They cut corners with staff pay and conditions, cheap vehicles and equipment.

Service would be better if office staff planned work properly for example sending one man crew to pick a 25st patient or sending two crews to the same patient or sending crews for patients who have either passed away or had their appointment cancelled.

The company I work for use unqualified staff cut corners do not pay pensions holiday pay or sick pay do not issue a contract of employment or monitor hours worked they turn a blind eyesore most issues have used unqualified staff on acutely ill patients and more, they fail to comply with CQC rules treating the CQC WITH MILD CONTEMPT?

Appendix B

S75 Requirements as to procurement, patient choice and competition

(1) Regulations may impose requirements on the National Health Service Commissioning Board and clinical commissioning groups for the purpose of securing that, in commissioning health care services for the purposes of the NHS, they—

(a) adhere to good practice in relation to procurement;

(b) protect and promote the right of patients to make choices with respect to treatment or other health care services provided for the purposes of the NHS;

(c) do not engage in anti-competitive behaviour which is against the interests of people who use such services.

(2) Requirements imposed by regulations under this section apply to an arrangement for the provision of goods and services only if the value of the consideration attributable to the services is greater than that attributable to the goods.

(3) Regulations under this section may, in particular, impose requirements relating to—

(a) competitive tendering for the provision of services;

(b) the management of conflicts between the interests involved in commissioning services and the interests involved in providing them.

(4) The regulations may provide for the requirements imposed, or such of them as are prescribed, not to apply in relation to arrangements of a prescribed description.

The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

Procurement: general requirements

3. (1) When procuring health care services for the purposes of the NHS ….

(2) The relevant body must—

(a) act in a transparent and proportionate way, and

(b) treat providers equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership.

(3) The relevant body must procure the services from one or more providers that—

(a) are most capable of delivering the objective referred to in regulation 2 in relation to the services, and

(b) provide best value for money in doing so.

(4) In acting with a view to improving quality and efficiency in the provision of the services the relevant body must consider appropriate means of making such improvements, including through—

(a) the services being provided in a more integrated way (including with other health care services, health-related services, or social care services),

(b) enabling providers to compete to provide the services, and

(c) allowing patients a choice of provider of the services.

Appendix C

Modern Role of PTS

This service is provided to patients who are physically or medically unfit to travel to hospital out-patient appointments by any other means. The service also handles non-emergency admissions, discharges, transport of palliative care patients and a variety of other specialised roles.

Patient transport vehicles come in a variety of forms and are usually staffed by Ambulance Care Assistants, whom work either double or single crewed. They are trained to look after patients during the journey, and to provide basic care.

Transport is provided for people who are unable to use public or other transport due to their medical condition. This includes those:

- attending hospital outpatient clinics and community-based care
- being admitted to or discharged from hospital
- needing life-saving treatment such as chemotherapy or renal dialysis.

The Wider Traditional Ambulance Service Role

The UK ambulance service started after the Second World War in 1946. Initially the service was staffed by volunteers but the Millar report of 1964 made recommendations including that patients should be treated on their way to hospital. As a result of the Millar report, training schools were set up. Training was basic first aid with a few add extended skills in the use of Oxygen, Entonox etc. Early ambulances were kitted out to very basic standards compared to what is considered usual today.

From 1974, each ambulance service was transferred to the NHS area that it served and as a result, differences in training and equipment soon started to arise, a trend which still happens today.

In 2001 the Health Professions council (HPC) was formed, from this point on it became illegal to call yourself a Paramedic unless you appeared on the HPC register. Other grades and roles are not protected.

Today ambulance services have to be dynamic and their remit is changing, the formation of Hazardous Area Response Teams, Rapid Response Vehicles, and Emergency Care Practitioners together with an ever demanding and growing public will ensure that the UK ambulance service has to be capable of change.

The specific skills performed by each group of emergency medical personnel will be dictated by a combination of training, the legal framework and the policies of their employer. The most homogenous group is the paramedics, as the framework of practice is largely dictated by their status as registered healthcare professionals, although local policy differences are still in effect.

The other grades, including technicians, support workers and emergency care assistants do not have legal status as health care professionals, and their skill sets and permitted interventions are governed by their employer. This has led to significant differences in training and skill between staff in different services with the same or similar job titles, especially within the private sector.

Appendix D

Published Research

Perhaps the best summary of research is provided in "*Non-emergency patient transport: what are the quality and safety issues? A systematic review*" by Isla M. Hains, Anne Marks, Andrew Georgiou, Johanna I. Westbrook first published online on 1 December 2010[22].

Abstract

Purpose: Patient transportation is an important component of health-care delivery; however, the quality and safety issues relating to non-emergency patient transport services have rarely been discussed compared with the transport of emergency patients. This systematic review examines the factors associated with the quality and safety of non-emergency transport services.

Results: Twelve articles from seven countries were included. Five studies examined issues relating to the structure of transport services, which focused on the use of policies and protocols to assist the transfer process. All studies addressed factors associated with the transfer process such as communication, appropriateness of personnel, time to arrange transfers, and the safety and efficiency of the process. Outcomes were measured in one study.

Conclusions: Communication, efficiency and appropriateness are key factors that are advanced as impacting on the quality and safety of non-emergency transport services. Standardization of the non-emergency transport process shows promise in reducing risk and increasing efficiency. Applying information and communication technology to improve the quality of transport services has received little attention despite its potential benefits. Patient outcomes in relation to quality and safety of transport services are rarely measured.

Available evidence suggests that safety of non-emergency patient transfers is sometimes compromised due to poor standardization and failures in communication processes.

[22] https://academic.oup.com/intqhc/article/23/1/68/1798760/Non-emergency-patient-transport-what-are-the

Appendix E

UNISON Survey Questions

We are producing a report about the effects of privatisation on patients and staff and are seeking the views of those who provide patient transport services, and have worked in the public and/or private sector.
We may anonymously publish responses provided however we will not identify staff or patients.

1. I currently work in a

- ◯ NHS Ambulance service
- ◯ Private ambulance company
- ◯ Both

2. Do you provide patient transport services?

- ◯ Yes - only patient transport services
- ◯ Yes - patient transport services and emergency response
- ◯ No

3. I have previously been transferred between an NHS organisation and a private ambulance company

- ◯ Yes
- ◯ No

4. Which of the following statements best describes your views about the patient services your organisation provides

- ◯ The services are better when provided by the NHS
- ◯ The services are the same whether by NHS or private organisation
- ◯ The services are better when provided by a private organisation
- ◯ Other (please specify)

5. Can you give us examples of how you feel privatisation has affected patient care? All responses will be kept anonymous and we will not publish names or patient details.

6. How have your conditions changed following privatisation?

	Worse	No change	Better
Pay	○	○	○
Pensions	○	○	○
Working conditions	○	○	○
Personal safety	○	○	○
Patient safety	○	○	○
Training opportunities	○	○	○
Career development	○	○	○
Equipment	○	○	○
Uniform	○	○	○

Other (please specify)

7. What ambulance service do you work for? (optional)

- ○ South Western Ambulance service
- ○ South central Ambulance service
- ○ South East Coast Ambulance service
- ○ London Ambulance service
- ○ Welsh Ambulance service
- ○ West Midlands Ambulance service
- ○ East Midlands Ambulance Service
- ○ East of England Ambulance Service
- ○ North East Ambulance Service
- ○ Yorkshire Ambulance Service
- ○ North West Ambulance Service
- ○ Scottish Ambulance Service
- ○ Northern Ireland Ambulance Service
- ○ Isle of Wight Ambulance Service
- ○ A private ambulance service
- ○ Other (please specify)

8. Who is your employer? (optional)

Published and printed by UNISON, UNISON Centre, 130 Euston Road, London NW1 2AY.
CU/April 2017/24330/UNP 14666/150.