Non-Emergency Patient Transport Service Consultation Response

Full consultation document available here:
https://www.engage.england.nhs.uk/consultation/eligibility-for-non-emergency-patient-transport/user_uploads/b0712-consultation-on-eligibility-criteria-for-non-emergency-patient-transport.pdf

This NHS England and NHS Improvement survey is one part of the consultation on the updated eligibility criteria for Non-Emergency Transport Services. The survey is open until 25 October 2021.

Healthwatch Islington is particularly interested in this consultation because we continue to hear reports from residents that the service doesn't work well for them. We raised concerns about the equity of access and lack of transparency around criteria back in 2019 when a revised contract was introduced by some providers locally.

From conversations with residents, carers and health and social care colleagues we know that transport eligibility criteria are applied inconsistently within and between services resulting in confusion, inconvenience, missed appointments, and demands on staff time. The decision-making criteria are not transparent or clear. There are issues regarding escorts being accepted or not (and then the impact of this on the person they are escorting being accepted not – an escort deeming them ineligible or for dementia patients a lack of escort deeming them ineligible). Transport provided does not always match the needs of the residents; and there currently (August 2021) appear to be issues with residents in wheelchairs not being accepted.

We have prepared this response to NHS England's consultation based on the conversations we've had with residents over the last two years.

Background

The overarching principle of NHSE's proposals is that: "Most people should travel to and from hospital independently by private or public transport, with the help of family or friends if necessary. NHS Funded patient transportation is reserved for when it is essential to ensure an individual's safety, safe mobilisation, condition management or recovery".

Patients would only be eligible for NHS Patient Transport if they have been referred by a doctor, dentist, or ophthalmic practitioner for non-primary care NHS-funded healthcare services ie diagnostics or treatment or are being discharged from NHS-funded treatment.

Healthwatch Islington has had concerns about how the criteria are applied and we welcome the opportunity to feed in to the consultation.

Qualifying criteria

NHS England has a list of criteria for assessing eligibility for patient transport. For the last few years Healthwatch Islington has expressed concerns about the lack of clarity around these criteria and how they are applied. Please see the full consultation document for the criteria. Respondents are asked to agree or disagree with these.

Based on what we hear from residents and carers we feel that these criteria cover the kind of needs that we would expect to be supported by Non-Emergency Patient Transport Services.

However, Overall, we disagree that these are the right criteria. Our experience of these services in the last 24 months is that providers are not clear about how some patients meet the criteria and others don't. **The lack of clarity in the wording of existing criteria has created ambiguity, confusion and unfairness.**

Locally, a resident using UCLH services may qualify for transport, but the same patient doesn't qualify at Whittington Health or Moorfields. It is clear that current providers are applying different algorithms to identify eligibility, and as these are so opaque even the patients don't know why they qualify on one day and not another. We would welcome **greater transparency of criteria** from NHSEngland and from all providers so that patients who are deemed ineligible are able to understand why, and to challenge that decision if it seems incorrect.

There is greater clarification needed regarding those **residents, eligible for NHS care, who are living in a residential care home**. Further definition is needed regarding what constitutes 'suitable transport to healthcare treatment'. The way criteria have been applied in Islington has resulted in residents with severe dementia being told to use public transport instead of NEPTS, or care home staff being expected to leave other duties and take residents to appointments when previously they would have been eligible for NEPTS. This has felt like a shifting of responsibility from the NHS to social care, when social care is not resourced to provide this kind of support. It has resulted in some local people missing appointments to which they were entitled.

It would also be helpful to have illustrative examples of 'a medical condition or disability that would compromise their [the patient's] dignity or cause public concern on public transport or in a taxi'. Call handlers are left to make this decision based on an algorithm and a limited understanding of the needs of people with access requirements rather than on the individual's experience. Someone who is visually impaired may be a regular user of public transport and be very able to access healthcare in this way, whilst for another this could be a very challenging exercise. Providers and call handlers need to demonstrate a broader understanding of the needs of people with medical conditions and disabilities so that appropriate reasonable adjustments can be made when assessing eligibility.

The consultation document suggests that in some cases patients could be directed to emergency ambulance services. We assume that the decision to use 999 transport services would only apply

in cases where equipment was needed that is found in an emergency ambulance and not in a non-emergency ambulance as we know that 999 services are extremely stretched.

Cognitive or sensory impairment. The consultation sets out specific criteria around cognitive and sensory impairment (such as dementia, visual impairment).

We welcome this specific recognition of the needs of people with dementia. However, this needs to be considered alongside the potential need to have a family carer or someone known to the patient attend with them. It feels unfair that being accompanied, to reduce disorientation, could then result in you not meeting the eligibility criteria.

One of our current local transport providers won't take people with dementia unless they can bring a carer, and as soon as the person says they can bring a carer they are suddenly deemed capable of attending via public transport and ineligible for patient transport.

For those who have cognitive impairment and may be confused about where they are and what is happening, it seems both more practical and more dignified to permit an accompanying carer on patient transport, particularly where journeys are long, complex, or to an unfamiliar location.

However, carers often have needs of their own and greater specificity is needed around when a carer taking someone on public transport is appropriate or not. Dementia, for example, is a very wide-ranging condition. For some residents and their carers this could add unnecessary distress.

Significant mobility need. The consultation document outlines what constitute 'significant mobility needs'.

We agree that assumptions should not be made about the impact of someone's mobility on their ability to travel and that some qualifying criteria are helpful. However, we think the definition of 'self-mobilise' is too limited and that it's important that clinical staff and assessors have a better understanding of what offers are actually available to residents.

Taxi cards are available to eligible disabled people who fulfil certain criteria but cannot be obtained for one-off needs, so the patient would need to have a long-term mobility need. London's Dial-a-ride will not take patients to healthcare appointments as they cannot guarantee arrival times.

Furthermore, this point should not be impacted by whether an escort/ carer can accompany the person to their appointment.

Mobility should not be re-assessed for every appointment where patients have a long-term mobility need. This wastes time.

The consultation asks for a view on defining someone's ability to 'self-mobilise' and whether and how to take into account the use of equipment and assistance.

In the context of healthcare appointments, surely the definition of 'self-mobilise' needs to relate to the ability to get to the appointment; down the street to the bus stop, on to a bus (or in to a taxi if the patient can afford it) and to the healthcare service and in to the relevant department. If a person can self-mobilise in this way, then they don't need transport. One of the assessment questions asked locally is whether you've been able to see your GP in person, but GPs are generally located closer to people's homes than hospitals, making this an unfair comparison. And for GPs patients usually have an appointment time, whereas for hospital treatment you might need to be there all day, making finding a family member/ friend to accompany the patient much harder.

We have heard of a local example where a woman was considered able to self-mobilise because she could walk a few steps, very slowly, to the patient transport from her front-door. As a result, the transport offer was withdrawn. NEPTS is commissioned to increase access not to cause unnecessary stress and result in missed appointments.

Likewise, when considering the use of aids and equipment, assessors should consider how regularly patients have used these before the day of the appointment, how confident they feel and whether relying on this equipment could impact on their ability to attend.

Thanks to the hard work of Kidney Care UK to influence this policy, the consultation proposes that all patients receiving in-centre haemodialysis patients should qualify for transport support or either specialist transport, non-specialist transport or rapid reimbursement?

Agree. And we agree with the recognition that this should be led by the needs of the patient.

Do you agree with a shared-decision making model between dialysis patients and the NHS to select the appropriate mode of transport?

We potentially agree, depending on who is having the conversation with the patient. This conversation needs to be had with a qualified medical professional who has an understanding of the types of needs dialysis patients may experience and some knowledge of the individual patient. Leaving this negotiation to call handlers to have with patients makes it less likely to be based on need and more likely to be based on cost-saving targets and we would strongly disagree with that approach.

The consultation proposed that if there is a safeguarding concern raised by a relevant professional in relation to the patient travelling independently, requiring oversight by a suitably trained driver or other patient transport member of staff then the patient should be eligible for transport.

We agree. To some extent it feels like this point is already covered above by previous criteria, but if there was a concern that someone would not be safe on their own but didn't have mobility, cognitive or other needs, then at least this covers them.

Wider mobility or medical needs. The Review reinforces the assumption that those with less significant mobility needs should travel independently but that there should be room for discretion.

We disagree. We are not convinced that discretion facilitates fairness, particularly given existing inequities in the application of criteria. We could define an overly complex journey (changing bus more than once, or buses operating less than once an hour. Regarding time of day, if someone is being discharged in the evening when there is less public transport (rural areas) or transport may feel more intimidating after dark, then why not always include this factor in decision-making, rather than 'at discretion'. If call handlers were acting in the interests of patients, then use of discretion would be a positive thing, but it currently feels like discretion is used to refuse people access.

Our experience is that call-handlers are not adept at understanding the needs of residents with disability, mobility needs, and other vulnerabilities that could make them eligible for transport services and as such need support to make effective and fair decisions. As such discretion seems problematic. Alternatively, if we could train and support call-handlers to offer discretion in a way that made the offer more flexible to patient need we would welcome this.

Particularly concerning is limits to taxi costs. Traffic in London (for example) is extremely bad. A short journey can take a very long time depending on the time of day of your appointment. It does not seem right to pass this cost on to patients. Likewise, it penalises people living in more rural areas. If taxis are too expensive, why not ensure that there is sufficient capacity with existing transport services to cover this need.

The tone of the consultation implies patients desperate to take patient transport at any cost, but our experience is that residents do make alternative arrangements if they are able, and it's those who can't access in other ways (ie those for whom this service exists) that are using the transport services.

Local decision-making: The consultation asks whether local areas should decide the level of discretion given to different authorised assessors, reflecting local pathway management and transport service management arrangements, rather than seeking to set this nationally.

We are not convinced it is ever particularly easy to set arrangements locally when budgets are imposed centrally. Of course there is room for some flexibility but demands on all budgets has been very pressured for some time now.

Because of regional differences in service provision and locations, and the different transport options available in different areas of the country, we can see an argument for allowing some regional differences. However, the NHS is a national health service, and residents from all across the nation have paid for this service through taxation, so everything possible should be done to minimise difference of outcome based on where we live.

Should other travel options be exhausted prior to the provision of patient transport.

The existing list seems exhaustive and patient transport is not offered to everyone, only those who, having read the criteria (or whose clinician has read the criteria) are likely to put themselves forward and as patients tell us, you wouldn't choose this transport if you could make your own way because it often takes a long time.

Escorts and carers

We think the policy on carers and escorts is short-sighted. Carers and escorts are not allowed and yet there would have been space for them on the transport. Carers and escorts themselves often have high needs. It feels very unsympathetic and not at all person-centred to be so militant about not allowing escorts. We have had examples of patients being deemed eligible and then their 90 year-old carer having to separately travel on the bus to support them at the hospital. This really doesn't make sense to us. Travelling to hospital can often be quite scary for patients, they may be travelling for care for life-threatening conditions, where's the harm in allowing someone along to give them emotional support.

There is an ongoing issue of patients with dementia who are not able to orientate themselves to get to an appointment needing to bring a carer but then potentially being deemed ineligible for transport if they can come with a carer yet also being ineligible if they are not accompanied.

Wider support - the review intends to ensure that patient transport co-ordinators provide better signposting to wider transport support, as well as when transport already funded by social security benefits or social care should be accessed instead of patient transport.

The list of options put forward have many different criteria. The whole system is overly complicated.

From Healthwatch Islington's work (2016) in this area we know that the Healthcare Travel Costs Scheme is not really promoted, not well understood by NHS providers and fairly impractical in terms of the claims process. Staff need regular briefings to ensure that they are aware of the offer, and who is eligible. We would encourage all providers to make claims processes easier,

offering on-line and postal options (with pre-paid envelopes) rather than expecting people to claim on-site.

DLA mobility payments are stopped after someone has been in hospital for 28 days, so provision also needs to be made for these circumstances. DLA has been superseded by the Personal Independence Payment for new adult claimants, and information for patients and services should reflect this.

Reducing variation. The review aims to reduce variation by providing greater specificity and through the universal offer of transport support for renal patients and enhance access to the healthcare travel costs scheme and wider transport options.

The consultation talks both about using discretion and reducing variation. Clearer criteria and a more transparent application of the criteria would help with both of these points.

It's positive to have a universal offer for renal patients. The emphasis on the travel costs seems to miss the point, as this could simply mean refunding a bus fare. It's not clear that NHSE are clear about how these pathways work in practice.

The review implies that lots of patients using patient transport could have simply used the healthcare travel costs scheme but these are clearly aimed at very different groups of service users and we don't seen any evidence locally that those using patient transport services could be re-directed in this way. We would welcome greater quantitative data from NHSE to make their case.

Exacerbation of existing inequalities under the Equality Act 2010 and beyond.

We think these proposals pose the following risks under the Equality Act 2010 and wider inequalities:

- Gender – we think the impact is unlikely to be different based on gender, although as we have seen with maternity services, perhaps assumptions could be made about people's gender and their ability to make their own way to appointments.
- Age – older residents are more likely to be users of these services and more work should be done to communicate the eligibility criteria, clearly, through groups working with older people. The narrow definition of 'self-mobilise' could impact older patients adversely.
- Disability – to mitigate the impacts on people with disabilities more guidance is needed on when those with disabilities are or are not eligible. For those whose condition will not change it is a waste of time to keep re-assessing them. Residents with Learning Disability may find it harder to self-advocate, and those with mental health needs may have conditions that fluctuate and processes must take this in to account.

Patient who travels by stretcher and was refused patient transport: “I never wish to take patient transport as it involves waiting around for hours on end and is physically painful for me and my wife, yet I cannot change my disability. They are behaving in an unprofessional and discriminatory manner and I hope I never have the misfortune to need DHL patient transport again.”

- Ethnicity – in general our work shows that refugee and migrant communities are less aware of services and support on offer. Criteria should be shared across a wide range of community partners.

We are concerned that the assessment process itself impacts adversely on some groups. It is long, repetitive and questions and criteria unclear. We feel this impacts on some ethnic groups where English may not be the first language spoken, particularly given that some of the criteria are not very clear but the criteria themselves probably don’t disadvantage residents based on ethnicity, faith, orientation, gender re-assignment, marital status or pregnancy.

Friend calling on behalf of patient who is elderly and deaf: “How does the hospital expect a patient in his position to go about doing something as simple as booking this NHS transport if this system is so flawed and inconsiderate?! If I hadn't been around to push for this then [the patient] would have been totally helpless in this case”.

Son speaking to us on behalf of elderly, disabled father: “It is ridiculous that I have to keep calling each time as my dad is 84 years old and his illnesses and disabilities are only going to get worse. Why do we have to go through this time and money wasting of have to book every appointment.”

- We think that the needs of carers have not been properly considered, and as the criteria are unclear in places.
- We think those with lower literacy/ who have lower levels of educational attainment may be less likely to be able to assert their rights and challenging decisions and so any use of discretion needs to be well informed and rigorously reviewed.

This consultation will close in October 2021. Following this, the final updated published criteria will be published in April 2022. It is NHS England’s ambition that newly planned services from this date onwards reflect the new criteria, and that existing services use it by April 2023. We assume that this is a realistic timeframe and are happy with this proposal as long as communication about transport arrangements are also increased.