



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.

Residents tell Healthwatch Islington that the service doesn't work well for them. We have been raising concerns about unclear criteria since 2019 (when changes were made to *'the way criteria were implemented'* at the request of NHS England).

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 is not transparent or clear. Our main local providers, Whittington Health, Moorfields and University College London Hospital contract two different transport providers, DHL and G4S. As an example of this inconsistency, Healthwatch Islington has had queries where the same patient, with the same needs, has qualified for transport to UCLH through G4S but been told they are not eligible through DHL for transport to Whittington Health.

Furthermore, 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 has been particularly poor practice in relation to patients who use a wheelchair (not always being accepted) and patients who have dementia.

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

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.

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. Residents tell us that providers do not clearly explain why they don't qualify when transport is refused by call handlers. Referrals for transport often come from a clinician. If a clinician thinks a patient is eligible but the call handler does not, this is confusing for patients.

Providers seem to rely on an algorithm to 'calculate' a person's eligibility. This means a person-centred approach is not provided, patients are simply allowed to answer yes and no, with no consideration given to their personal context.

- There is a need for much greater clarification regarding those **residents, eligible for NHS care, who are living in a residential care home**. Often NHS-funded providers expect stretched care-home staff to escort patients in taxis or on public transport to get them to hospital. Social care is under-resourced and there is limited capacity for this.
- There is a need for much **greater clarification of '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 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’. Again, it is problematic that call handlers are making decisions based on an algorithm. Therefore, decision-making is not clinically-led, demonstrates a lack of understanding of client needs, and does not give the individual a chance to be heard. For example, 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. This is confusing and inappropriate.** Patients should not be directed to over-stretched emergency services which are already struggling to meet demand.

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 and raises anxiety.

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, **the definition of ‘self-mobilise’ must 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. This particular question comes up a lot when we talk to local residents. Patients feel they are tricked in to being deemed ineligible. Patients (or the care worker calling for them) are not told why they are ineligible, and then have to make a formal complaint and often their complaints are upheld. Complaints processes are cumbersome and add to the distress, and waste further time.

In one local example, 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. 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. Some explanation needs to be given about how discretion can be applied. 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.

Healthwatch Islington’s 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, Healthwatch Islington feel that this is not justified and demonstrates a lack of understanding about patient need from NHS England and policy makers. Healthwatch Islington’s 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 see 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.

Healthwatch Islington does not believe that sufficient regard is being given to patient needs under the Equality Act 2010. We think these proposals pose the following risks under the Equality Act 2010 and wider inequalities:

- 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."

- Gender – we think the impact is unlikely to be different based on gender, although if call handlers have not had sufficient equalities training perhaps assumptions could be made about people's gender and their ability to make their own way to appointments. This has historically been the case in maternity services where Black patients are less likely to be offered support than White patients. Analysis should be carried out of whether more men or women's complaints about transport eligibility are upheld.
- Ethnicity – in general our work shows that refugee and migrant communities are less aware of services and support on offer. Clear 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."

- Healthwatch Islington believe that the needs of carers have not been properly considered, and that the criteria are unclear about carers rights to accompany their loved one,
- We think those with lower literacy/ who have lower levels of educational attainment may be less able to assert their rights and challenge decisions because criteria are so hard to interpret. As such, any use of discretion needs to be well informed and rigorously reviewed.

Final criteria will be published in April 2022 for use 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.

This specific consultation is only about the eligibility criteria. However, Healthwatch Islington has also received a wide range of feedback covering; length of time taken to get through to the booking system, difficulty changing a booking when an appointment has to be re-arranged, fragmentation of the system meaning the complaints system is difficult to access, staff not always having the skills/ capacity to help people on to transport (one resident was badly injured by a driver who may not have had sufficient experience supporting wheelchair users). In addition there have been issues with transport arriving late, or getting patients to their appointment late, or driving off without a patient who has taken 'too long' to get on to the transport because of their mobility needs.