Response to NHS Non-Emergency Patient Transport Services Review

A*BILITY Community Transport & *CommMiniBus

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1. Forewords

1.1. The NHS plays a vital part in ensuring the health and wellbeing of each and everyone in the country. However, to be able to access services, patients need transport services.

1.2. Current level of funding for buses in the country has dropped to a historical low figure, shifting many trips made by public transport to cars.

1.3. However, we are facing the huge problem of ageing population. It is time the NHS planned with foresight and made preparations to cope with the forthcoming challenges.

1.4. We appreciate the fact that the NHS welcomes opinions from patients, carers and transport professionals. We hope there will be a radical change which fully prepares our healthcare system to adapt to the challenges ahead and make healthcare service accessible for all.

2. Background

2.1. We are ***A*BILITY Community Transport** & ***CommMiniBus.*** We are social enterprises operating on a not-for-profit basis. Ability CIC is a community interest company.

2.2. We are service providers of community transport services. Ability CIC operates a flexible community transport schemes connecting rural communities and towns, places of interest and health-care facilities. CommMiniBus is getting set at the moment for the commencement of a similar pilot scheme as well as to operate traditional fix-route minibus service.

2.3. In what region are you based?
We are currently based in Northamptonshire, the Midlands of England.

3. The challenges facing non-emergency patient transport services in England.

3.1. Some services offered by GPs have been moved to hospitals, meaning that patients have to travel further and find it more difficult to travel.

3.2. Some non-urgent appointments are made for the same day, so it is hard for some patients to arrange transportation.

3.3. Current non-emergency patient transport is not flexible enough - the time for pickup may not best suit patients' habit or needs. *Some patients were taken to the hospital and had to wait for long hours. (E.g. patients having diabetes) and needed to be provided with food from the hospital.*

3.4. Duration of appointment and geographical locations are not linked - not taking into account where patients are travelling from - those who live further can take appointments later.

Patients travelling long distances (over 15 miles) to attend appointments around 09:00 are being picked up hours before the appointment time.

3.5. The use of taxi as an alternative provision from the NEPT providers for people who have had surgery or treatment is not the ideal solution. Drivers are not trained to take care of them, in terms of care provided and driving.

3.6. Some patients are used to driving but they suddenly cannot drive following advice from the hospital - they might not meet criteria of NEPT. Other patients also have travel needs but are not taken care of.

3.7. There are problems in coordinating the logistics and travel pattern - the current time window is too big. Patients need to wait for a long time for pick-up.

The patient stayed up all night as she was told that the NEPT would pick her up between 06:00 and 09:00 and she wanted to be ready to go to hospital.

3.8. There is not always room for a relative or carer to travel with the patient and it is difficult to advise when they will get home.

An elderly patient was kept in the discharge suite until the early hours of the morning and eventually arrived home at 06:30 where his wife was waiting up for him and was scared to go to bed on her own.

3.9. Patient's condition deteriorated on arrival back home following being deemed fit to leave the hospital. The volunteers from AGE (UK) had to call the hospital and emergency services to get them re-admitted. They waited

for three hours and they then took the patient back themselves to A&E as the ward could not accept them.

3.10. Operators are not cooperating with each other to create more impact or to utilise resources.

3.11. Existing NEPT vehicles are not well utilised. Most of the times they are only carrying a few patients, when the seating capacity for a minibus is 9 to 16.

3.12. No-show rate could be high. Volunteers have been called out to assist the NEPT provider and the details given where the patient was located was not on the site they had been sent to but 3 miles away.

3.13. Sometimes, journeys are cancelled at very short notice after a patient requests the journey, only to be told the trip is not required. The NEPT provider does not pay the voluntary organisation for the call out and aborted trips, while resources have already been allocated. This causes wastage of resources.

3.14. The previous NHS long-term plan lacks focus and consideration on how patients travel. Decision makers of NHS are often not transport professionals, making it challenging for the organisation to identify the best option and managing NEPT.

3.15. In addition to hospital visits, the travel needs for recovery, recuperations and ongoing healthcare support have also been overlooked.

3.16. Interestingly, patients are less concerned over transport for specialist interventions such as surgery, but they are more concerned over how to travel for regular appointments and follow-up care.

3.17. Those with learning disabilities or mental health issues have concerns when using transport and need extra support. Particularly the elderly who are suffering with dementia.

3.18. Issues regarding “SAFE WAY HOME”, by having trained and caring staff to deal with the patient all the way to settling them in to their home environment, has also been overlooked.

A 85-year- old gentleman had been taken home in the early hours of the morning and dropped off at his gate, when he got to his house he found he had been broken into and had to call the police. The NEPT provider should have had a duty of care to the patient as the patient was vulnerable.

3.19. NEPT is restricted to those who are entitled to the service. However, the wider community suffer with great burdens of getting to and from hospitals.

Imagine getting up early and going on a bus and having to change buses and struggle through the commuter traffic to be seen for a 10 minute appointment which invariably runs late.

4. Good or innovative practice examples

Better logistical arrangements catering for patients' transport needs

4.1. Improved appointment booking system where patients' travelling time or distance is made aware to the staff taking the booking - A travel plan for patients should be developed and staff should be trained to cater for patients' travel needs.

4.2. Integrated booking platform - With technology, an integrated system can be created so appointments and NEPT can be booked at the same time, and operators will be shared the information of the booking and details of patients.

Transport service available for all

4.3. Hospitals with a nearby transport hub can make use of its location to reduce the costs involved in NEPT.

4.4. With a well connected transport hub, fixed scheduled bus services connecting hospitals and transport hubs can be provided, if the number of users is considered high and stable.

4.5. The timetable can be designed to connect other bus or train services. This gives hospitals visitors more certainty and they can plan for connecting journeys more easily.

4.6. For hospitals serving a wider (or rural) communities, the flexible approach could be adopted due to the complexity of travel patterns.

4.7. As proven practical in Ability's operation model, flexible pre-booked and pre-arranged minibus services have the potential in fulfilling users' travel needs with minimal on-going financial support, if services are well-designed and well-utilised.

4.8. Zones can be created according to the locations of patients and a flexible route can be created for each zone, making sure NEPT could be available in communities where patients live.

4.9. There is an opportunity that the concept of total transport can be implemented. An integrated system could be developed, as suggested

above, to eliminate the need for patients to book with the service operator after making an appointment with the hospital.

5. Suggestions about how to improve services within available resources.

5.1. There is no one-size-fit-all solution due to the complexity of travel patterns of patients and hospital visitors. A dedicated travel plan should be drawn up for each hospital.

5.2. Whether to adopt the fixed-route or flexible approach depends on whether there exists a well used transport hub nearby, as well as passenger demand.

5.3. Over-reliance on volunteers means services are subject to availability of volunteers and are thus not sustainable such as car schemes which are suitable for one to one trips. These vehicles are unlikely to take wheelchairs and mobility aids as they are privately owned vehicles who receive a mileage allowance.

5.4. Some investment is required to support service providers, especially at the early stage. However, from the success of the previous schemes, if the model of operation and location are carefully selected, minimal on-going support is required for a flexible bus scheme.

5.5. The government reimburses bus operators off peak bus journeys made by the English National Concessionary Travel Scheme - bus pass holders. The NHS can partner with community transport operators to make use of the financial support.

5.6. The use of standard / adapted vehicles (Minibus v specialised) may lower the cost of operation and subsidy required.

5.7. Service should be made available for others passengers who will be paying for the service so they can get transport service they need and contribute to the financial sustainability of the services.

5.8. Bearing in mind that passengers of NEPT are quite often wheelchair users and occupy additional space, the financial position of NEPT might not be as good as other current schemes. However, the key is to endeavour to get more passengers on board the same bus, so cost of service provision can be spread among passengers, and / or to carry other passengers who have similar travel needs, to make services more financially efficient.

6. Additional comments relevant to the review that you wish to make

6.1. The problem faced by rural communities is much harder than urban regions, due to the unavailability of off-peak public transport service in rural locations.

6.2. In reality, villagers refrain from visiting GPs even if they feel unwell, due to transport matters, causing delayed treatments and missed appointments.

6.3. In addition to the wastage of resources, the call-out rate of emergency services rises when patients are not retreated early.

6.4. This should be borne in mind when making decisions on how to fund non-emergency hospital transport.

6.5. The NHS could partner with transport operators, to have medical students or trainees available as drivers or passenger assistants for NEPT journeys. This enhances the standard of care provided to patients who may have medical needs during the journeys.

6.6. Optimising Capability is vital - there is transport capacity available within the Community Transport sector for other parties, including NHS, to utilise.

6.7. Below is the typical regular services operated by community transport organisations:

- Scheduled services from 09:30 to 14:00 each day; and
- Services provided to day centres from 08:00 to 10:00, with a return from 15:00 to 17:00.

From above, there is significant capacity available.

6.8. Community Transport operators have the capacity to provide a contribution to the overall NEPT system by utilising existing idle vehicles, drivers and carers to improve the overall delivery of NEPT.

7. Conclusion

7.1. NEPT is vital for patients, enabling them to get the crucial medical care and services.

7.2. Coordination of patients due for discharge is critical as the best time to take patients home is from 11:00 after doctors rounds, medication and discharge letters completed and the patient is ready, dressed in appropriate clothing, packed and the home care packages in place. Therefore the best time for NEPT discharge is 12:00 - 19:00

7.3. Problems of the existing operation have been identified. A system approach has to be adopted - the way patients are booked or admitted,

how booking slots are allocated, and how transport is arranged requires a complete rethink and integration.

7.4. Besides those qualified for NEPT, opportunities have been identified to make use of the subsidised service to benefit other patients or visitors. If this is impossible under current regulations, there should be other schemes which take care of the transport needs of other hospital users.

7.5. Many community transport organisations have the resources and expertise in place and are more than welcome to provide service using their spare capacity, without needing a huge amount of grant or funding from the NHS.

7.6. It is hoped that more cooperation between the healthcare and community transport sector can be seen in the future to further improve the wellbeing of people.

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