NHS Non-Emergency Patient Transport Services (NEPTS) review - call for evidence

Submitted 13 March 2020

1. **In what (main) capacity are you responding?**

Other;
"Umbrella group, representing 34 members including patients, health care professionals, charities and professional associations

2. **If responding on behalf of an organisation / public body, please state organisation's name:**

The Taskforce for Lung Health

3. **In what region are you based?**

N/A - National or regional organisation

4. **If you would like to receive updates on the Non-Emergency Patient Transport Review please provide an email address:**

hinksr@csp.org.uk

5. **Please share your insight, examples, and data, on the challenges facing non-emergency patient transport services in England:**

The scope of NHS England's review into Non-Emergency Patient Transport Services (NEPTS) should focus both on the challenges facing transport services themselves; but also how the commissioning and provision of transport services affect other NHS activities and the experiences and health outcomes for patients.

Academic literature shows that travel and transport are among the most important factors that limit uptake, attendance, and completion of pulmonary rehabilitation (PR).[i] A common theme of 'issues with getting there' is evident in studies assessing barriers to PR, either because of lack of access to a car or public transport, lack of physical mobility or because of the cost of hiring a taxi. These themes also emerge in reviews of other forms of rehabilitation, such as cardiac rehabilitation.[ii]

Yet despite this, pulmonary rehabilitation services are under-served by transport services for patients and carers.

The Royal College of Physicians argue that low attendance rates seen for initial assessments indicate that a range of barriers prevent access to pulmonary rehabilitation services, including the availability of transport (Pulmonary Rehabilitation national organisational audit report 2015).

The RCP's audit of PR programmes in England and Wales (2015) audit found that:

- Just 12% of services within the audit (*n* = 81) provided funded transport to all that required it;
- 22% (*n* = 150) provided some funded transport but only against local transport provision criteria;
- 43% (*n* = 288) did not provide funded transport services, but did signpost to information about voluntarily provided services;
- 23% (*n* = *151*) provided no transport services at all

The 2019 report from Healthwatch, Age UK and Kidney Care UK, 'There and Back Again,' suggested that people are less concerned about travelling long distances for specialist treatments like surgery, but more concerned about travelling for regular treatment. Given the frequency which people are required to attend PR classes – up to twice a week for six to eight weeks – access to reliable and low-cost transport is clearly a determinant of attendance and completion.

There are strong links between lung disease and health inequalities. COPD prevalence is around 2.5 times greater in the most deprived 20% of the population (British Lung Foundation, Battle for Breath, 2016). The associated costs of frequent travel can limit a person's ability to attend and complete PR if they have a limited income. People with COPD are also more likely to be over 65 and reliant on pensions.

The audit also showed there is considerable variation in transport provision depending on the type of site rehabilitation is delivered from:

- 69% (n = 59) of services operating out of acute hospitals provided some funded transport (whether available to all, or against local eligibility criteria).
- This is the same for 61% of community hospital-based services (*n* = 69);
- 40% (*n* = 23) for those operating out of health centres;
- 20% (*n* = 29) of those in leisure centres or gyms; and
- 17% (*n* = 35) of those operating out of community halls.

With the literature demonstrating that there is no evidence that programmes delivered in non-healthcare settings are inferior to other sites of delivery (RCP organisational audit 2015), these services may offer advantages of proximity to patients' homes and improved access to public transport. Delivering services through 'hub and spoke' models closer to the community could reduce transport needs and

help to co-deliver other NHS priorities such as its net zero ambitions and reductions in air pollution.

However, transport consideration still needs to be made for people who have very limited mobility. This may be particularly true for people who are severely limited by breathlessness, with an MRC score grade of 4 or 5. All PR services should have an offer of transport for people who genuinely cannot travel through their own means.

Further data on Pulmonary Rehabilitation services' transport provision will be available through the RCP's 2018- continuous audit of pulmonary rehabilitation services. Data from this audit will be available later this year (summer 2020) and should be considered in the latter stages of NHSE's wider review into NEPTS services.

6. **Please share good or innovative practice examples, including use of technology, if possible with supporting links:**

NA

7. **Please share your suggestions about how to improve services within available resources:**

Non-emergency patient transport services need to be treated as an integral part of wider patient pathways. As per the RCP National COPD Audit Programme (2013–18 Pulmonary Rehabilitation workstream), the commissioners and providers of services that serve populations (both patients and carers) that find it difficult to walk, or require support during travel, should routinely consider the availability of transport when considering their referral pathways and other aspects of service deliver.

Commissioners should assess the accessibility of venues when considering new services or when redesigning existing services. NHSE PR service guidance recommends venues be easily accessible to patients in view of choice of locality, adequate parking and good public transport links. Situating venues in the community and mapping of existing community or volunteer transport services may be useful.

Eligibility criteria, for patient and carer-transport services, and other information that could be used to benchmark services - such as funding levels - should be readily available for all relevant services. Commissioners and providers should document this information in their Standard Operating Procedures.

The inclusion of questions concerning patient transport services in the RCP's Pulmonary Rehabilitation audit should be replicated in other NHS- and independent-run audits of NHS services.

National policies and guidance documents could be reviewed to lever the above changes at service level. Given the recognition that people who are geographically

isolated represent an Inclusion Health Group, relevant goals and outcomes within the NHS Equality Delivery System (ERS2) (e.g. Goal 2.1, Improved patient access and experience) could be reviewed to ensure NHS Commissioners are directed to consider patient transport issues when analysing their performance through discussions with local stakeholders.

Likewise, official guidance for NHS Commissioners on their legal duties regarding equality and health inequalities (NHS Guidance Reference number 04511) could be reviewed to ensure commissioners are instructed to consider and record the impact of their commissioning of patient transport services on health inequalities.

Further levers to improve NEPTS could include: dedicated and expanded guidance on NEPTS included in resources accompanying the CCG Assurance Framework, CCGs Annual Equalities Reporting documentation, Joint Strategic Needs Assessment documentation, and other documents through which NHS Organisations are expected to detail how they meet their Public Sector Equalities Duties.

https://www.england.nhs.uk/about/equality/equality-hub/eds/
https://www.england.nhs.uk/wp-content/uploads/2015/12/hlth-inqual-guid-comms-dec15.pdf

8. **Any other comments, relevant to the review, that you wish to make:**

NA

9. **If you provide an email address you will be sent a receipt and a link to a PDF copy of your response**

hinksr@csp.org.uk

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[i] For example: Keating A et al, "Lack of perceived benefit and inadequate transport influence uptake and completion of pulmonary rehabilitation in people with chronic obstructive pulmonary disease: a qualitative study," *Journal of Physiotherapy 57: 3 (2011).* Keating A et al, "What prevents people with chronic obstructive pulmonary disease from attending pulmonary rehabilitation? A systematic review," *Chronic Respiratory Disease*, 89–99 (2011). Sabit R et al, "Predictors of poor attendance at an outpatient pulmonary rehabilitation programme," *Respiratory Medicine* 102 (6); 2008.

[ii] For example: Beckie T et al, "Predicting Cardiac Rehabilitation Attendance In A Gender tailored Randomized Clinical Trial," *J Cardiopulm Rehabil Prev* 30 (3): 2010. Resurreccion D et al, "Barriers for Nonparticipation and Dropout of Women in Cardiac Rehabilitation Programs: A Systematic Review," *J Womens Health* 26 (8): 2017. Murray J et al, "A systematic review of patient reported factors associated with uptake and completion of cardiovascular lifestyle behaviour change," *BMC Cardiovascular Disorders* 2012.