

Classification: Official

Publication approval reference: PAR682



# Improving non-emergency patient transport services

Report of the non-emergency patient  
transport review

Version 1, August 2021

# Contents

Foreword .....	2
Executive summary .....	3
The importance of patient transport .....	3
Non-emergency patient transport today .....	3
Challenges and opportunities .....	4
A new national framework for patient transport.....	6
Implementation .....	9
1. Introduction: the importance of patient transport .....	11
2. Non-emergency patient transport today.....	13
2.1 Non-emergency patient transport services .....	14
2.2 The healthcare travel costs scheme .....	19
2.3 A framework for patient transport – co-ordination, specialist services, non- specialist services, reimbursement, and wider transport facilitation.....	21
3. Challenges and opportunities .....	22
3.1 Challenges for patients .....	22
3.2 Challenges for providers, commissioners, and health systems.....	25
3.3 Challenges in reaching net zero.....	28
3.4 Uncertainty in demand .....	29
3.5 Opportunities.....	30
3.6 Learning from the COVID-19 response.....	35
4. Objectives .....	37
4.1 Responsive .....	37
4.2 Fair.....	38
4.3 Sustainable .....	39
5. A new national framework for non-emergency patient transport.....	39
5.1 Updated national guidance on eligibility .....	40
5.2 More accessible advice and support for patients .....	44
5.3 Transparency to incentivise responsiveness and enable learning and accountability .....	47
5.4 A clear path to net zero patient transport .....	50
5.5 Improving procurement and contracting to incentivise responsiveness and sustainability .....	52
5.6 Implementation .....	58
6. Next steps.....	62

# Foreword

As the Expert Advisory Group to the Non-Emergency Patient Transport Review, we very much welcome this report.

For people with a medical or severe mobility need, non-emergency patient transport services (NEPTS) provide an essential means to access the NHS. In some places the services work well. However, there are also too many instances where patients do not receive a sufficiently timely and high-quality journey. These problems are often the consequence of poor commissioning, uncertainty about eligibility and a lack of information on service activity and performance. NEPTS also constitutes around a fifth of direct NHS travel emissions of carbon dioxide and need to accelerate their transition away from fossil fuels.

The development of the new national framework for NEPTS set out in this report provides the foundation for addressing these issues: updated national eligibility criteria; improved wider transport support; greater transparency; a clear path to net zero emissions; and better procurement and contracting. It provides a basis for greater consistency, while recognising that needs vary from one place to another and services should be tailored to reflect these.

As the NHS recovers from the pandemic and integrated care systems (ICSs) assume responsibility for NEPTS, it will now be important for all stakeholders to translate this framework into action at local and national level; ensuring that services are consistently responsive, fair and sustainable.

## **NEPTS Review Expert Advisory Group**

Caroline Abrahams (Age UK)

Anna Parry (Association of Ambulance Chief Executives)

Russell Hobbs (G4S Patient Transport)

Peter George-Jones (Guys and St Thomas' Healthcare Trust)

Imelda Redmond (Healthwatch)

Alan Howson (Independent Ambulance Association)

Fiona Loud (Kidney Care UK)

Peter Kottlar (Sussex CCGs)

Rod Barnes (Yorkshire Ambulance Service)

# Executive summary

1. Our experience of healthcare does not start and stop at the hospital door. Transport to and from treatment can make a significant difference to patients' wellbeing, and sometimes to their safety and health.

## The importance of patient transport

2. When Healthwatch undertook an extensive nationwide conversation about improving the NHS, nine out of ten people highlighted the importance of convenient ways of getting to and from health services. Age UK, Kidney Care UK and other patient groups have emphasised similar conclusions; and how transport can be a major challenge to many patients today.
3. This report sets out measures for improving an important element of travel to healthcare: NEPTS. These NHS funded transport services support those people whose medical condition or mobility constraint would otherwise be a major barrier to getting to treatment. It draws on the findings of a national Review, which has worked closely with the sector. Our aim is to ensure that NEPTS is more responsive, fair and sustainable.

## Non-emergency patient transport today

4. While most people can travel to treatment independently or with support from family and friends, NEPTS play an important role for those whose medical condition or severe mobility constraint means that other forms of transport are not suitable.
5. NEPTS deliver 11-12 million patient journeys each year, covering around half a million miles each weekday.
6. Out of every 20 journeys, approximately nine are for patients attending outpatient appointments, seven renal dialysis, and four are discharges or transfers to other hospital settings. Three quarters of users are aged over 65.
7. Patient transport services typically have four components:
  - **Co-ordination and triage capacity** – to assess eligibility, broker and manage journeys, and signpost people to independent transport.

- **Specialist transport services** – for those who need adapted vehicles or support from staff with particular training. There are up to 300 Care Quality Commission (CQC) registered ambulance providers delivering these services.
  - **Non-specialist services** such as private hire/taxis and community transport – some areas now draw on over a hundred providers to flexibly deliver to those with less severe needs.
  - **Reimbursement** of travel costs to allow patients or their families to cover the costs of private transport. In addition, those on a low income or meeting other criteria are entitled to reimbursement through the **Healthcare Travel Costs Scheme**.
8. We estimate that around £460 million is spent on NEPTS a year – at an average cost of around £38 per journey. That represents about £1 in every £275 spent by the NHS, approximately the same as the total cost of radiotherapy.
  9. Data from a small number of healthcare trusts suggests that the use of the Healthcare Travel Costs Scheme is comparatively low. Extrapolating from this small sample indicates that national expenditure may be around £5-10 million a year.
  10. Patient transport emits 57-65 kilotonnes of carbon dioxide equivalent emissions per year, which constitutes approximately 20% of the NHS' direct travel emissions, as well as contributing to increased air pollution levels.

## Challenges and opportunities

11. Patients often enormously value the transport they receive. The review has heard many examples of how the approximately 10-15,000 full time equivalent (FTE) staff and hundreds of volunteers provide patients with good care and support.
12. Since the advent of the COVID-19 pandemic, providers of transport have shown enormous flexibility. They have adapted to social distancing requirements, often involving a rapid shift from group to individual transport. They have stepped up to develop better ways to safely discharge patients from hospital. Collaboration between providers has deepened.

13. However, alongside these positive examples, the review has found that patient transport services are too often variable in quality and responsiveness. For example, one survey found that on at least one occasion in the previous two years, nearly a third of patients had waited over three hours for transport back from treatment. People are also often left uncertain as to when their transport will arrive, creating needless waiting and anxiety.
14. Eligibility for NEPTS is inconsistently applied across England, with each Clinical Commissioning Group (CCG) typically developing their own interpretation of government guidelines.
15. Service commissioning, planning and management has been poor in some areas. We estimate around a quarter of journeys are cancelled or aborted each year – around 3 million trips – an indication that communication and integration between providers of healthcare, transport and patients could be much better. Commissioners and providers also expressed concerns about procurement and contracting. We are aware of four contracts being handed back or terminated in 2017 and 2018 alone.
16. Nor is the sector yet environmentally sustainable. Patient transport needs to be at the forefront of the NHS' commitment to become the first net zero carbon healthcare system by 2040.
17. These challenges have arisen due to systemic factors: the inherent uncertainty around eligibility; a lack of data and transparency undermining both good commissioning and accountability; and contracts that do not incentivise investment or innovation.
18. The positive news is that there are also significant opportunities to address these issues. Technology in transport co-ordination is allowing demand and capacity to be much better connected. Measures to reduce the need for outpatient appointments by 30% should free up travel resource for reinvestment in other parts of NEPTS and reduce emissions. ICSs provide the institutional architecture for healthcare providers to collaborate in planning and delivering transport better. The expansion of electric vehicle charging infrastructure and increased availability of electric vehicles enables reductions in carbon emissions and improvements in air quality.

## A new national framework for patient transport

19. The needs and opportunities identified in this review define three major objectives for non-emergency patient transport: to be more consistently **responsive, fair** and **sustainable**:
  - NEPTS needs to be high-quality and consistently patient-centred: minimising waiting times, keeping people informed, better integrating transport into the treatment pathways and giving people more control.
  - More detailed national eligibility criteria and consistent standards are required to underpin good local planning and delivery.
  - NEPTS needs a clear path to net zero carbon, to work with local communities and continuously improve productivity through investment and innovation.
20. This review therefore sets out a **new national framework for non-emergency patient transport**, comprising of five components.
  - i) **Updated national guidance on eligibility for transport support** to:
    - (a) Clarify eligibility for those with a medical need, cognitive or sensory impairment, significant mobility need, or safeguarding need.
    - (b) Introduce a new universal commitment to transport support for all journeys to and from renal dialysis, offering access to appropriate specialist transport, non-specialist transport or simple and rapid reimbursement of patient costs, planned through shared decision making.
    - (c) Reinforce the expectation that people will otherwise be responsible for their own transport, while allowing discretion where treatment or discharge may otherwise be significantly delayed or missed.

Specific proposals for consultation are published alongside this report. Subject to this consultation, we expect that they will be incorporated into new contracts from April 2022 and existing contracts from April 2023.

ii) **Support for wider transport planning and journeys for all patients.**

We propose to:

- (a) Significantly simplify the process for accessing the Healthcare Travel Cost Scheme (HTCS) and integrate the scheme far more closely with NEPTS and wider transport co-ordination. The ambition is to process reimbursement in a matter of days, with an absolute maximum of 30 days for valid claims compared to up to 90 days at present.
- (b) Ensure, at a minimum, that all patients can access advice on alternative travel options, including community transport.
- (c) Support the growth of community transport, particularly volunteer recruitment and integration with transport co-ordination hubs; with innovative approaches developed in three pathfinder areas.

We will seek to implement these changes as rapidly as possible, including working with DHSC to make any legislative changes required to the HTCS by the end of 2023 at the latest.

iii) **Increased transparency**, to incentivise patient-focused provision and enable greater learning and accountability. This will include:

- (a) Model activity measures and **key performance indicators** (KPIs) to allow more consistent monitoring of patient experience, communications and satisfaction, journey delivery and value for money.
- (b) A **national minimum dataset** covering key elements of patient journeys including volumes, waiting and journey times for different types of journey. These will be published every six months.

More detailed proposals are available on the FutureNHS Collaboration platform. Following engagement with stakeholders, we will publish the final measures by March 2022 so that the first tranche of national data can be published by the end of 2022.



- iv) A clear path to a **net zero NHS patient transport sector**. The NHS is committed to net zero and therefore is committed to using a fully zero emission fleet across all operations. The NEPTS providers engaged in this review have shared this commitment.

We expect the NHS as a whole to have a fully zero emission fleet ahead of its commitment to become net zero by 2040. Within this, we expect all NEPTS vehicles, except ambulances and volunteers using their own vehicles, to be zero emission by 2035, irrespective of contract duration. To achieve this target a progressive gradual decarbonisation of NEPT vehicles has been agreed, which apply to contracts issued or renewed after the set date below.

**Table 1: NEPT vehicle decarbonisation timeline**

Date	Vehicle emissions targets
From 2021	No immediate changes
From 2023	50% of vehicles used to deliver the contract are of the latest emission standards, ultra-low emission vehicles (ULEV) or zero emission vehicles (ZEV)
From 2026	75% of vehicles used to deliver the contract are ULEV or ZEV, including minimum 20% ZEV
From 2030	100% of vehicles used to deliver the contract are ULEV or ZEV, including minimum 20% ZEV
<b>2035</b>	<b>100% of vehicles used to deliver the contract are ZEV</b>

At a later date, NHS England and NHS Improvement will set out plans for when it expects all ambulances to be zero emission; NEPTS providers will need to comply with future plans for ambulances and this will be reflected in further guidance and standards.

- v) **Better procurement and contract management**, to improve service responsiveness and enable investment and innovation we:
  - (a) are providing initial advice in this report and further best practice principles/proposals on the FutureNHS collaboration platform which we will continue to develop with the sector. We advise that:

contracts for core specialist provision are agreed for a minimum of five years, comprise of a combination of fixed and variable payments, and that tender processes run for a minimum of 60 days; and that non-specialist provision draws on wider transport markets.

(b) will clarify core standards for specialist and non-specialist provision

(c) introduce model service specifications with specific elements, covering co-ordination, specialist provision, non-specialist provision and reimbursement.

Core standards and model specifications will be available by December 2022 following joint development work with the sector.

## Implementation

21. This is a strategic framework to enable local improvement. From April 2022, subject to legislation, NHS ICS bodies would assume responsibility for overseeing NEPTS and transport support more widely.
22. It would be for NHS ICS bodies to determine how best to deliver this responsibility, but we expect that in addition to implementing the five components of the national framework:
  - Each ICS body should have a lead officer with responsibility for oversight of non-emergency patient transport.
  - In line with the aims of ICSs, healthcare providers should be closely involved in the planning, commissioning and management of services to ensure that transport forms an integrated part of wider pathway improvements including discharge, outpatient transformation and renal services.
  - Oversight and budget management should look at NEPTS delivery, reimbursement, the Healthcare Travel Costs Scheme and wider transport facilitation in the round.

- Each ICS body should consider coordinating with other system-level and regional partners including urgent and emergency transport providers, local authorities and neighbouring ICSs where appropriate.

23. We anticipate that the impact of the above changes will enable significant improvements in patient transport within the same financial resources:

- We consider that the outpatient transformation programme should release at least 4% of NEPTS resources by 2023/24 which can be redirected to address additional resource pressures arising from the updated eligibility criteria, particularly the universal renal transport support offer, and greater use of the HTCS. This is based on a conservative estimate of resources released and engagement with areas on the implications of the new eligibility criteria.
- We also anticipate that productivity should be improved through introduction of longer-term contracts to enable investment, a more differentiated approach between specialist transport, non-specialist transport and reimbursement, and better use of co-ordination to improve utilisation.
- The cost of purchasing and leasing zero-emission vehicles will fall over the next decade, with battery powered electric vehicles expected to reach cost parity with internal combustion engine vehicles by 2030 or earlier.

The delivery of these measures assumes that patient transport services are no longer significantly impacted by the COVID-19 pandemic. If infection prevention and control measures are still in place from April 2022, it is possible that the timetable for the delivery of some actions may need to be reassessed.

24. To support the delivery of the measures set out above, NHS England and NHS Improvement is establishing a dedicated NEPTS Review implementation programme, led by a small team. The team will work closely with transport providers, patient groups, ICSs, and regional teams to deliver these actions. This will include a senior level Implementation Advisory Group, ensuring that the work is supported and challenged by experts and representatives of all these groups with a stake in better patient transport.

# 1. Introduction: the importance of patient transport

Our experience of healthcare does not start and stop at the hospital door. Our journey to and from treatment often makes a significant difference to our wellbeing, and sometimes our safety and clinical condition.

In 2019, the Healthwatch network engaged with over 30,000 people about the implementation of the NHS Long Term Plan. This community-based engagement highlighted that convenient ways of getting to and from health services was important to nine in 10 people.<sup>1</sup> In two thirds of the country, communities told Healthwatch that they wanted more focus in local plans on improving the links between transport and health and care services.

For the vast majority of patients, journeys to and from healthcare treatment are something they are able to manage on their own. But some need additional support. For instance, according to research by Age UK and the International Longevity Centre, around 1.45 million people over 65 find it quite difficult or very difficult to travel to a hospital.<sup>2</sup>

Each weekday, over 20,000 people use NHS non-emergency patient transport services.<sup>3</sup> These provide an essential conduit for those whose medical condition or significant mobility constraints mean that they would otherwise struggle to access care. For example, people who receive haemodialysis treatment in hospitals or satellite units, typically three times a week, say that transport to and from the dialysis unit is one of the most important issues affecting their quality of life (see box 1).<sup>4</sup> For people who would otherwise be housebound, these services enable them to access important check-ups. For patients whose conditions or needs change, such transport will enable them to be transferred from a local hospital to a specialist centre.

---

<sup>1</sup> Healthwatch (2019) There and back  
<https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20191016%20People%27s%20experiences%20of%20patient%20transport%20Formatted%20final.pdf>

<sup>2</sup> The future of transport in an ageing society: <https://ilcuk.org.uk/the-future-of-transport-in-an-ageing-society/>

<sup>3</sup> NHS NEPTS Activity data – 11.5m journeys, mainly on weekdays (although some renal and discharge journeys will be on weekends), is 44,000 two-way trips for 20,000+ patients

<sup>4</sup> Kidney Care UK, Renal Association, British Renal Society, National Kidney Federation (2019) Dialysis transport – Finding a way together

## Box 1: Travel for dialysis

Around 21,000 renal patients in England need haemodialysis treatment in hospitals or satellite units. They usually receive treatment three times a week; over 300 journeys per patient every year, often for the rest of their lives.<sup>5</sup>

Given this, patients say that transport to and from the dialysis unit (and time spent waiting for that transport) is one of the most important issues affecting their quality of life, overall health and disease outcomes. The importance of getting patient transport right has been highlighted by Kidney Care UK, the Renal Association and many other groups and patients.<sup>6</sup>

Our survey of 64 renal dialysis units indicates that around 62% of patients use NEPTS all of the time and a further 7% some of the time – probably accounting for over 4.2million journeys each year.

Likewise, initial estimates suggest that around 2,000 people on a low income receive reimbursement for travel costs each weekday. They might otherwise have to make a choice between travel to hospital and other essential expenditure.<sup>7</sup>

Responsive, reliable and safe non-emergency patient transport is therefore an important element in our healthcare systems. We estimate that such transport:

- supports between 11 and 12 million patient journeys each year<sup>8</sup> – around double the number of emergency journeys – covering around 140 million patient travel miles<sup>9, 10</sup>
- accounts for around £1 in every £275 of NHS expenditure – about the same as is spent on radiotherapy<sup>11</sup>

<sup>5</sup> <https://renal.org/about-us/who-we-are/uk-renal-registry>

<sup>6</sup> [There and back - what people tell us about their experiences of travelling to and from NHS services | Healthwatch; PREM-report-2019-final-web-copy.pdf \(renal.org\)](#)

<sup>7</sup> Estimates based on very small sample size – see HTCS section

<sup>8</sup> NHS NEPTS Activity data, HTCS data collection

<sup>9</sup> 5.6 million face-to-face with transport in 2019-20 ([Statistics » Ambulance Quality Indicators Data 2019-20](#), [england.nhs.uk](http://england.nhs.uk)).

<sup>10</sup> NHS NEPTS Activity Data

<sup>11</sup> From national schedule of costs <https://www.england.nhs.uk/national-cost-collection/>

- emits between 57,000-65,000 tonnes of CO<sub>2</sub>e annually, which includes a provisional estimate of around 6,000 tonnes of CO<sub>2</sub>e attributed to HTCS journeys.

This report sets out the conclusion of a comprehensive review into how to deliver this transport better: for patients, providers of healthcare and transport, the environment, taxpayers and communities.<sup>12</sup>

We are enormously grateful to the many people who have shared their experiences, provided analysis and insight and contributed ideas and time to the process, especially to the local areas who helped us test our thinking. This report aims to reflect these vital contributions from across the sector.

## 2. Non-emergency patient transport today

As described above, NEPTS provide funded transport where a medical condition means that a patient would struggle to safely attend their treatment independently.

In addition to NEPTS, the NHS provides some additional transport support. The HTCS reimburses costs for those people on a particularly low income and who meet statutory entitlements to support. Many healthcare providers go further – such as signposting people to travel options and working with local authorities to improve public transport to hospitals.

### Box 2: Definitions

Throughout this report we refer to:

- **NEPTS** as those services/journeys which are contracted by the NHS
- **Transport support** as those elements which are non-commissioned, including reimbursement, the **HTCS**, signposting and facilitation.

---

<sup>12</sup> <https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/nepts-review/>

The review which informs this report was focused on NEPTS. However, given the importance of a joined-up response to transport needs, this report also sets out some initial recommendations for the other components.

## 2.1 Non-emergency patient transport services

### Who is NEPTS for?

Most people make their own way to healthcare treatment, just as they do for any other activity.

Transport is a personal responsibility; central and local government supports that through transport infrastructure and subsidising public transport – at a cost of around £35 billion each year.<sup>13</sup>

The aim of NEPTS is to specifically provide NHS-funded transport where it is medically necessary. The Department of Health and Social Care (DHSC) set out the high-level criteria in guidance in 2007:

- Where the medical condition of the patient is such that they require the skills or support of Patient Transport Services staff on or after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
- Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
- Parent or guardians where children are being conveyed.

That guidance recognised that an assessment of needs should reflect the wider context, such as the length of the journey, frequency and other local circumstances. It also highlighted that in some cases a patient's escort or carer could be provided with transport too, where their particular skills or support are needed (eg for vulnerable adults).

---

<sup>13</sup> UK figures See table 5.4 [Public Expenditure Statistical Analyses 2018](https://publishing.service.gov.uk) (publishing.service.gov.uk)

Local areas have, over time, developed their own sets of more detailed criteria which seek to translate these principles to the needs of their populations. These are usually assessed with a standard set of questions to consider people's needs.

NEPTS is only available for a journey to healthcare treatment, an outpatient appointment or diagnostic service – that care traditionally provided in hospitals. It is not available for primary care, where alternative arrangements are provided for those unable to leave their homes for a consultation.

## How the system operates

NEPTS is provided by a range of organisations both public and private, including the voluntary sector, NHS Ambulance Trusts and large and small independent providers. There are nearly 300 ambulance providers registered with CQC, the vast majority of which will also provide some NEPTS transport.<sup>14</sup>

Since 2013, CCGs have been responsible for the commissioning of NEPTS. Patterns of commissioning vary significantly from place to place. For example, in the North West, five NEPTS contracts covering the whole region are managed by a single team. In Devon, some services are managed in an integrated way with the local authority. In much of London, CCGs operate arrangements in which hospital trusts take on responsibility for arranging patient transport.

## Use of NEPTS

This review has sought to develop a better understanding of who uses NEPTS and for what purposes. This information is not being routinely collected. The review therefore undertook new surveys. These include returns from 183 CCGs,<sup>15</sup> nine large transport providers that collectively provide over half of the national NEPTS journeys, and 64 renal dialysis units. They have allowed us to make some national estimates:<sup>16</sup>

- NEPTS provides around 11.5 million patient journeys each year, with an average distance of approximately 12 miles per journey.<sup>17</sup>

---

<sup>14</sup> 296 registered ambulance providers on CQC Care Directory <https://www.cqc.org.uk/about-us/transparency/using-cqc-data#directory>

<sup>15</sup> There were 191 CCGs in 2019-20

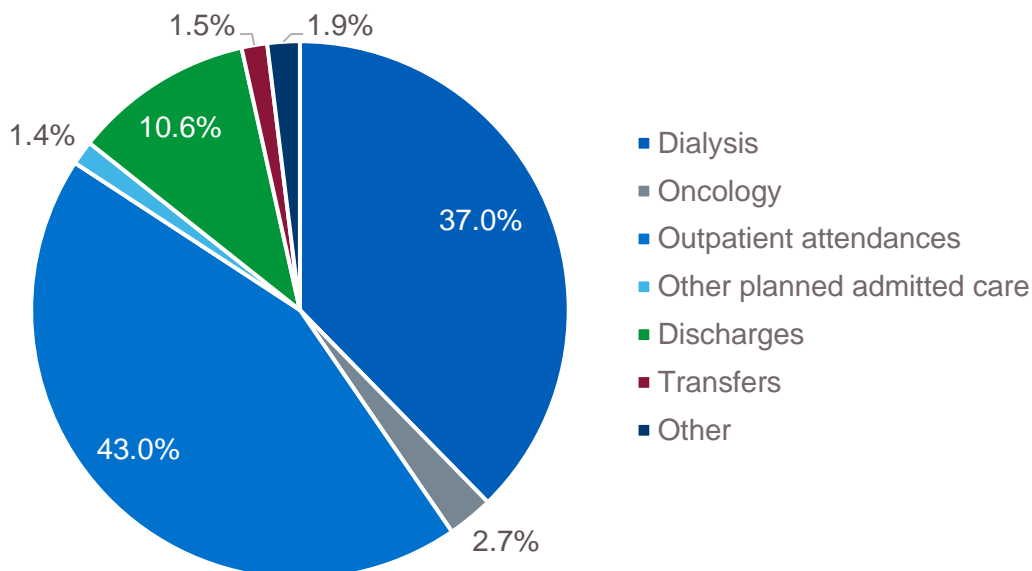
<sup>16</sup> Six out of 10 ambulance providers and three independent providers

<sup>17</sup> NEPTS Review activity data – we estimate between 11m and 12m patient journeys per annum and have used 11.5m for calculations, assuming a market split between NHS and independent providers of 45:55



- Around 43% of journeys are for outpatient attendances, excluding renal dialysis. Although a significant proportion of NEPTS journeys, this reflects transport to only about 3 in every 100 outpatient attendances.
- Around 37% of journeys are for patients requiring renal dialysis.<sup>18</sup>
- About 10% of journeys are for discharge, and the final 10% for 'other' reasons, such as planned admitted care, transfers between hospital and oncology appointments.<sup>19</sup>
- Around three quarters of patients transported are aged over 65.<sup>20</sup>
- In around one in eight journeys (13%) the patient is accompanied by a relative (an 'escort').<sup>21</sup>

**Figure 1: Estimated reasons for journey and age of patients<sup>22</sup>**



## Types of transport

A range of vehicles and support is required to deliver NEPTS. These include:

- **High dependency unit ambulances**, which will always have at least two staff with significant training.

<sup>18</sup> Our activity data from transport providers estimated around 31% of journeys were for renal dialysis, but a separate more detailed survey of renal units indicates the figure is more like 35-40%. Given we understand that some journeys classified as outpatients are for renal dialysis, we have used the higher figure and adjusted the outpatient figure downwards.

<sup>19</sup> NHS NEPTS Review activity data

<sup>20</sup> NHS NEPTS Review activity data

<sup>21</sup> NEPTS Review activity data

<sup>22</sup> NEPTS Review activity data, adjusted to reflect additional renal analysis

- **Stretcher ambulances and other specialist ambulances** (such as those with adaptations for bariatric patients), usually with two ambulance care assistants, trained to emergency first aid level with a regulated body.
- **Sitting and wheelchair accessible ambulances**, with one or two members of staff.
- **Cars**, with a driver, typically a trained ambulance care assistant, but sometimes with trained volunteers; occasionally with a medical escort.
- **Minibuses**, with a driver, typically a trained ambulance care assistant.
- **Taxis and private hire vehicles**, sometimes with mobility adaptations and drivers with some training.

Evidence for the review indicates that around seven out of 10 of journeys take place on a single-crewed vehicle (see Figure 2).<sup>23</sup> While it's hard to measure the exact level of patient support needed, this indicates that most people using NEPTS require only the assistance of the driver when they are not driving eg to get in and out of the vehicle or be helped to their destination. According to data returns from five large NEPTS providers, we estimate that around 10% of journeys require a specialist or adapted vehicle.

Infection control measures introduced during the COVID-19 pandemic have led to vehicles always carrying one or two patients. We have found mixed evidence on the typical number of patients on each vehicle prior to the pandemic. For example, analysis of one area suggests vehicles typically carried on average less than two patients per trip, and our returns from large providers typically supports that. Yet in another area, close to a third of renal transport journeys involved four or more patients.

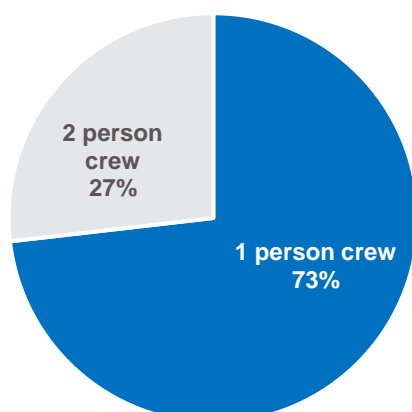
In addition, some NEPTS services reimburse people to use their own private transport if public transport is not suitable given their medical condition. An estimated 90% of renal patients and 65% of patients' families are currently able to claim reimbursement instead of using the transport provided, should they wish.<sup>24</sup>

---

<sup>23</sup> NEPTS Review activity data

<sup>24</sup> UK Dialysis Transport Survey, 2018

**Figure 2: Types of transport**



## Resources

We estimate that the NHS spends around £460 million a year on NEPTS. This averages to a cost of around £38 per patient journey.<sup>25</sup> The review has found a significant range of costs within this average. This equates to a little under 0.4% of NHS England expenditure – about £8 per head of the population.<sup>26</sup>

We estimate that the workforce required to deliver NEPTS is the equivalent of around 10-15,000 full time staff.<sup>27</sup> Hundreds of volunteers also contribute. We do not have the data to confirm exact staffing numbers, but the review understands that significant staff shortages or skills gaps are not widespread in the patient transport sector.

## Environmental impact

The NHS is committed to becoming the world's first net zero healthcare system by 2040.

We estimate that NEPTS journeys emit approximately 51,000-58,000 tonnes of CO<sub>2</sub>e equivalent annually, around 20% of emissions related to NHS delivery of care travel. This is equivalent to one person taking over 55,000 return flights from London to New York.

<sup>25</sup> This calculation is based on total cost estimates and total journey estimates. We recognise that costs will vary dependent on the type of vehicle and additional support needed per patient.

<sup>26</sup> CCG Spend data collection

<sup>27</sup> Assuming 70% of costs staff, average pay and overheads of £27,500 pa. 70% figure based on looking at one large NHS provider's annual accounts.

## 2.2 The healthcare travel costs scheme

The HTCS<sup>28</sup> aims to support people on a low income to cover the costs of transport to healthcare treatment. It forms part of the overall NHS low income scheme. HTCS was not the original focus for the NEPTS review, but we have come to see it as an important component of better transport and therefore we are making initial recommendations in relation to the scheme.

### Who is entitled to support?

To receive help with travel costs, patients or their partner must receive a qualifying benefit or allowance or satisfy other criteria. These include Universal Credit up to certain income limits, income support, income-based Job Seekers Allowance, income-based Employment and Support Allowance, working tax credit and child tax credit and those receiving Pension Credit Guarantee Credit, and children whose families are in receipt of these benefits. People may also be entitled if they meet the criteria for such help under the NHS Low Income Scheme (ie those whose capital resources do not exceed the specified capital limit and whose income does not exceed their requirements by fifty per cent or less of the amount of the charge).

- Around 6-7 million people were eligible in England prior to COVID-19 (around one in nine people), although during the pandemic the number of working age households claiming Universal Credit has increased significantly.<sup>29</sup>
- Of these, around 1.5 million are people over 65 years old on Pension Credit. The proportion of older people qualifying for Pension Credit has been falling over recent years as the State Pension has risen.<sup>30</sup>

In addition, the HTCS is available to:

- People who live permanently in a care home, or where a local authority pays towards the cost of the accommodation

---

<sup>28</sup> The Scheme is provided for in regulations made by the Secretary of State – the National Health Service (Travel Expenses and Remission of Charges) Regulations S.I. 2003/2382. See also guidance at <https://www.gov.uk/government/publications/healthcare-travel-costs-scheme-instructions-and-guidance-for-the-nhs>

<sup>29</sup> Note that figures include an assumption of eligible family members. [DWP benefits statistical summary, February 2020 – GOV.UK](#) (www.gov.uk)

<sup>30</sup> 1,574,000 pension credit claims in 2019 [DWP benefits statistical summary, February 2020 - GOV.UK](#) (www.gov.uk)

- Children in local authority care
- Asylum-seekers and their families, where they receive government support.

Like NEPTS, the purpose is to support travel to healthcare treatment rather than primary care.

## **How the system operates**

Reimbursement can be accessed through either hospital cashiers or claimed in advance or in arrears from the NHS Business Services Authority (NHSBSA). Funding is incorporated into the overall resources provided to NHS trusts and NHS foundation trusts rather than managed through a separate commissioner-held budget like NEPTS.

Most local processes stipulate the cheapest form of transport should be used and that taxis can only be booked by prior permission or are arranged on behalf of patients.

## **Use of the scheme, costs, and environmental impact**

No national statistics are available on HTCS use. The Review has therefore undertaken some analysis in a limited number of areas. Based on analysis from six acute trusts (in four regions) we found:<sup>31</sup>

- Together, these six trusts were responsible for around 35,000 claims with a combined expenditure in the region of £450,000-£500,000 per year.
- There was considerable variation between these trusts, with specialist teaching hospitals appearing to have higher average claim level – probably reflecting some longer distance journeys to appointments.
- Extrapolating from a small number of trusts has to be treated with extreme caution, but would imply NHS expenditure of £5-10 million per year, and potentially in the region of 500-700,000 claims per year.

It is difficult to assess how many people who could claim for the HTCS do not currently do so. In many areas, patients will already be eligible for concessionary or

---

<sup>31</sup> Awaiting additional data from Gloucestershire and North West.

free travel, so would not need to claim support via the HTCS. However, two studies indicate that only around one in 10 people are aware of the scheme.<sup>32</sup>

## 2.3 A framework for patient transport – co-ordination, specialist services, non-specialist services, reimbursement, and wider transport facilitation

A strict interpretation of the NEPTS high-level criteria set out by DHSC in 2007 might suggest that patients will always have severe medical needs. However, as set out in the sections above, our surveys indicate that, in practice, the system covers a spectrum of needs served by a wide variety of vehicles.

It is helpful to recognise the broad distinction between:

- **Specialist transport**, which will require trained staff, often an adapted/specialist vehicle where the provider will be registered with the CQC. This is because it is the nature of the vehicle design that determines whether a provider is carrying out a CQC regulated activity.
- **Non-specialist transport**, where a regular taxi or minibus is appropriate, patients do not usually need a fully-trained member of staff, and the provider does not necessarily need to be CQC-registered, but should deliver a high quality and assistive service. The requirement to be CQC registered will be dependent on the primary purpose of the vehicles being used.
- **Reimbursement**, for private or public transport either as part of NEPTS or the HTCS.

The NHS can also play an important role in **facilitating travel** for a wider group of patients who do not qualify for NEPTS or the HTCS. For example, at University College London Hospitals NHS Foundation Trust staff will book patients a taxi, which patients then pay for.<sup>33</sup> The NHS also now provides free car parking for people who are disabled or who attend hospital most frequently.<sup>34</sup>

---

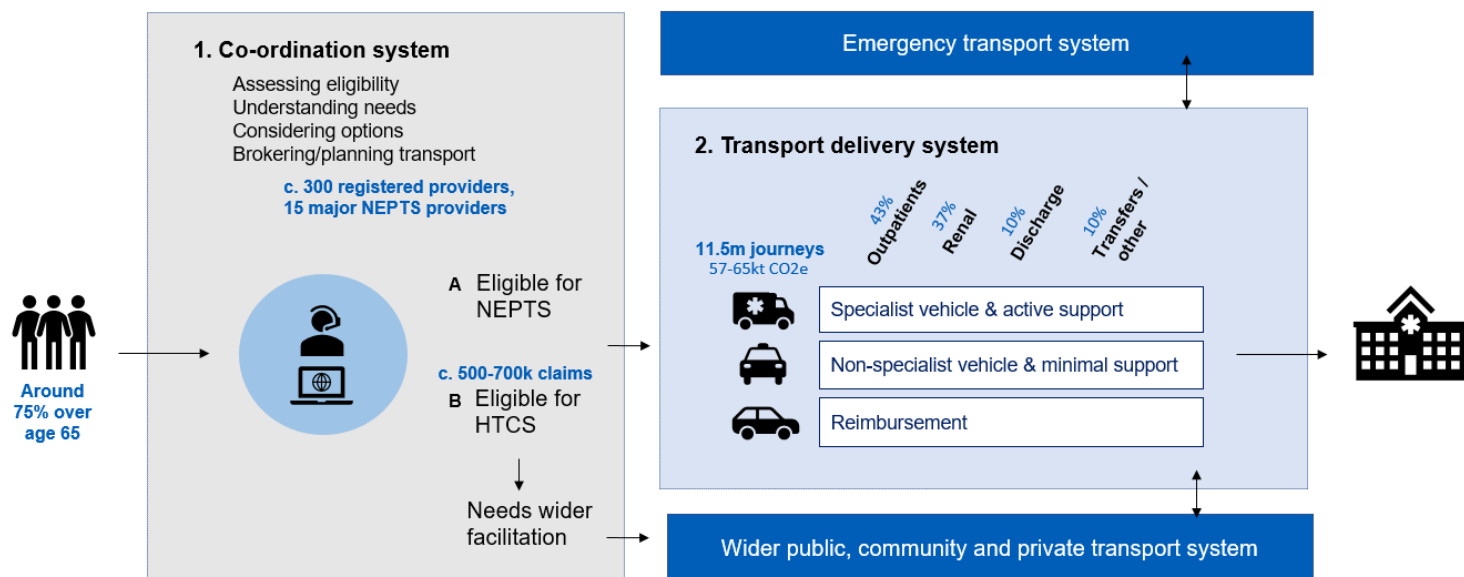
<sup>32</sup> Transport for All, 2014; Healthwatch Suffolk, 2015

<sup>33</sup> [After your outpatient appointment: University College London Hospitals NHS Foundation Trust \(uclh.nhs.uk\)](https://www.uclh.nhs.uk)

<sup>34</sup> [C1164-Patient-car-parking-23-March-2021.pdf \(england.nhs.uk\)](https://www.england.nhs.uk)

This diversity of needs, types of journey and vehicle types highlights the importance of good **triage and co-ordination, the interconnections with** emergency transport and wider public and private transport systems (see Figure 3), and the need to integrate with different care pathways.

**Figure 3: A simplified patient transport framework**



## 3. Challenges and opportunities

The NEPTS Review was launched in response to significant concerns highlighted by patient groups and charities, including Healthwatch, Kidney Care UK and Age UK, and by many in the patient transport sector themselves.

The review has found that patient experience, service quality and service sustainability vary significantly across England. Many services are good, but there is often scope for significant improvement.

### 3.1 Challenges for patients

NEPTS is highly valued by patients. There are many positive examples of patients being transported to and from their appointments by caring and compassionate drivers.

However, research and deliberations prior to the review highlighted several recurring issues that patients face when accessing patient transport. These were echoed in the 160 responses to the review's call for evidence.

The two most significant challenges reported by patients are:

### **(a) Co-ordination, communication and timeliness**

We have found that, nationally, around 5% of inbound NEPTS patients arrive after their appointment time. Based on data returns from five of nine large NEPTS providers, we estimate this means over 275,000 delayed appointments or treatments each year.<sup>35</sup>

This can vary significantly locally: one survey of 200 patients in London in 2014 found that in the previous two years:<sup>36</sup>

- 47% of patients had been late for a hospital appointment due to patient transport.
- 49% of patients had to wait over two hours to be taken home after their appointment, and 33% had to wait over three hours.

Our analysis indicates that average journey times are just over half an hour.<sup>37</sup> However, in some instances, patients report very long group journeys at the end of a long day of treatment and waiting. Patients also report that vehicles are not always appropriate to their needs.<sup>38</sup>

The Kidney Patient Reported Experience Measure (PREM) survey in 2019 of over 500 renal patients found an average score of 5.5 out of 7 for the quality of transport.<sup>39</sup> Although this appears positive, it was the joint worst outcome across all 13 domains of care, largely driven by waiting times. This improved significantly during 2020 (though remained tenth out of 15 experience factors) at a time when, due to distancing guidelines, multi-passenger services were frequently replaced with single-occupant vehicles and reimbursement schemes.<sup>40</sup>

---

<sup>35</sup> NEPTS Activity data – extrapolation based on 4.8% of 5.75M inbound NEPTS journeys

<sup>36</sup> Transport for All (2014) Sick of Waiting – A report into patient transport in London

<sup>37</sup> NHS NEPTS Activity Data

<sup>38</sup> Call for Evidence; NHS NEPTS Activity Data.

<sup>39</sup> Renal Association and Kidney Care UK (2019) Patient reported experience of Kidney Care in the UK <https://renal.org/sites/renal.org/files/PREM-report-2019-final-web-copy.pdf>

<sup>40</sup> Renal Association and Kidney Care UK (2020) Patient reported experience of Kidney Care in the UK <https://www.kidneycareuk.org/news-and-campaigns/prem/>



More generally, poor communication can be as much of a difficulty as waiting times. For example, in some areas, patients report having to be ready for collection in ‘2-hour windows’ but not kept informed. A patient in their 80s who responded to our call for evidence stated: “I find the hours waiting for the driver to turn up difficult, as I can’t see and am worried I will miss them when they arrive outside.”<sup>41</sup> Age UK shared examples with the review of older people concerned to go to the toilet while waiting, for fear that they might miss their transport.

Current HTCS arrangements mean that people generally pay for their own travel and then submit a claim for the cost to be reimbursed, either online or at a cashier’s desk in a hospital. The reimbursement process can take up to 90 days. Cashiers are often only open for limited hours. Administrative approaches vary by local area, and can be burdensome for patients and for commissioners.

## **(b) Variation in eligibility and access**

As noted earlier in this report, local areas have adapted the national NEPTS eligibility criteria; the vast majority of local areas have developed their own, more detailed interpretation of the 2007 eligibility guidance. In Cornwall, for example, attendance frequency is a criterion.<sup>42</sup> Sometimes, those discharging patients may prioritise a timely journey over medical need. Others operate stricter criteria.

Variation particularly affects patients with less severe needs, renal patients and patient escorts. For example, Age UK’s 2018 report, *Painful Journeys*,<sup>43</sup> highlighted that many older patients face the difficult decision between a long or uncomfortable journey on public transport with their companion or carer versus travelling alone on a patient transport service. They also emphasise that many older carers have health issues themselves, which may make travelling separately on public transport difficult. Similarly, in Macmillan Cancer Support’s response to this review, they noted that: “People living with cancer are often advised to bring someone with them when travelling to appointments. This can be challenging because carers of people living with cancer are very rarely eligible under NEPTS criteria”.

Although the number of people who apply for NEPTS that are turned down appears modest, data accessed by Healthwatch from 18 CCGs shows that the number of

---

<sup>41</sup> NEPTS call for evidence

<sup>42</sup> [Non-emergency NHS funded patient transport policy – NHS Kernow CCG – NHS Kernow CCG](#)

<sup>43</sup> Age UK (2018) *Painful Journeys* [https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/rb\\_dec17\\_painful\\_journeys\\_indepth\\_report.pdf](https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/rb_dec17_painful_journeys_indepth_report.pdf)

times people who applied but were deemed ineligible for NEPTS nearly trebled from 2015/16 to 2018/19.<sup>44</sup> Extrapolated to all of England, this would indicate that between 300,000-500,000 people are unsuccessful in their initial applications each year. Concerningly, a Healthwatch Northumberland report from 2018 found that around 70% of appeals are successful,<sup>45</sup> raising questions about the quality of decision making.

Patients report sometimes having to frequently be reassessed in terms of their eligibility; a time-consuming process which is distressing for some.

Patients have also highlighted a lack of active signposting across to alternative transport support, including the HTCS, voluntary schemes or community transport.

Our initial analysis does not find systemic inequalities in the distribution of transport spend by area of deprivation. Generally, areas with a higher Index of Multiple Deprivation record a higher spend on NEPTS per person. However, more detailed information is required to understand whether all are benefiting equally from access to NEPTS, the HTCS and wider transport support.

## 3.2 Challenges for providers, commissioners, and health systems

**Health systems suffer alongside patients if transport is delayed;** these delays create disruption and add unnecessary cost.

Healthcare providers have particularly highlighted the **importance of timely discharge** for people leaving hospital. Delays in patient transport can undermine both patients' continued recovery and wellbeing during discharge, and hold back the use of beds for others who need them, causing wider challenges for hospitals. Similarly, transport providers have highlighted challenges that increases in on-the-day discharges can have when contracts are not designed in a way which accommodates these among planned resources. As a consequence, some healthcare trusts have taken to arranging separate taxi or specialist NEPTS

---

<sup>44</sup> Healthwatch (2019) There and back: What people tell us about their experiences of travelling to and from NHS services: <https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20191016%20People%27s%20experiences%20of%20patient%20transport%20Formatted%20final.pdf>

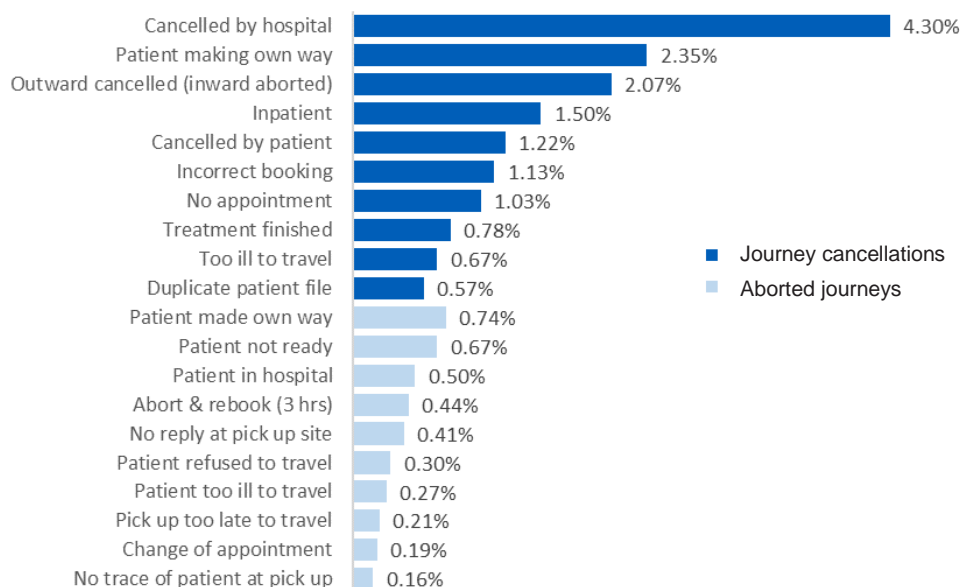
<sup>45</sup> Healthwatch Northumberland (2018) Insights into the non-emergency patient transport booking process for service users in Northumberland: <https://healthwatchnorthumberland.co.uk/wp-content/uploads/2018/02/Patient-Transport-Service-Insight.pdf>

services to speed up the discharge of patients, but such ad hoc approaches can make it more difficult to ensure appropriate quality.

As a result of increased concerns over quality, the CQC carried out a comprehensive review of independent ambulance services in 2018. This found that the quality and safety of services varied greatly, with variation in governance processes and checks to ensure that staff had appropriate Disclosure and Barring Service (DBS) certificates.<sup>46</sup>

A further challenge is the high number of **aborted and cancelled journeys**, **reflecting changing treatment times** and other variations in patient and health service circumstances. We estimate that up to 25% of booked journeys are cancelled or aborted each year.<sup>47</sup> Figure 4 sets out the reasons for one CCG, which had a cancellation or abort rate of around 23%. The greatest single cause was cancellations by hospitals, but the figures also point to wider miscommunication between operators and patients. There are valid reasons why transport might need to be cancelled by the hospital, but we heard that discharge planning taking place too late in the day or multiple bookings being made with different providers are contributing to increased cancellation rates.

**Figure 4: Example reasons for journeys being cancelled or aborted in one CCG, as a percentage of all patient journeys that month**



<sup>46</sup> Care Quality Commission (2019) The state of care in independent ambulance services <https://www.cqc.org.uk/publications/major-report/state-care-independent-ambulance-services>

<sup>47</sup> NEPTS activity data

The review received evidence on particular problems with the funding and management of long **'out of area' journeys**. These might be for specialist treatment or to bring back a patient who fell ill away from home. Examples include CCGs and trusts spending considerable time arranging ad hoc transport, or of providers struggling to maintain standards on routine journeys if vehicles and staff are diverted to carry out these longer journeys.

**More broadly, contracting and tendering** has been a significant issue in some areas. There have been high-profile difficulties with procurements and contracts in some parts of the country. For example:

- In 2017 and 2018, contracts were handed back or notice was served in Sussex,<sup>48</sup> Lincoln, Bedfordshire and Hertfordshire, and Warrington,<sup>49</sup> Cheshire and Wirral. In 2018, one tender resulted in no bids, and another was suspended.
- Several NHS Ambulance Trusts have highlighted challenges with the commissioning system as part of their submissions to this review, with one noting that it had spent approximately £1.3m in a single year on unsuccessful bidding.<sup>50</sup> The London Ambulance Service withdrew from provision in 2017, stating that the service had become financially unviable.<sup>51</sup>
- Equally, a number of independent providers have ceased trading or withdrawn from the market. For example, in 2019, one of the main providers – Arriva Transport Services – announced plans to exit the market and SSG Ambulance Company went into administration.

Both commissioners and providers have expressed frustration at how uncertainty on passenger volumes and patient needs and risks in contracts are managed. Providers have highlighted that they often are expected to take on contracts without enough information on passenger numbers/needs or mechanisms to address variation; or simply that contracts are underfunded. Commissioners have

---

<sup>48</sup> Thames Group UK, <https://thamesgroupuk.com/nhs-trust-turn-down-240000-that-could-have-saved-sussex-jobs/>

<sup>49</sup> HSJ, <https://www.hsj.co.uk/west-midlands-ambulance-service-nhs-foundation-trust/trust-pulls-out-of-25m-transport-contract-/7022292.article>

<sup>50</sup> NEPTS Call for evidence

<sup>51</sup> London Ambulance Service Annual Report 2016/17

highlighted that they have to 'pick up the costs' of underperforming providers if contracts are handed back.

These problems, and the consequential impacts on patients, haven't arisen by chance. Underlying them are a series of **systemic challenges**:

- **Inherent uncertainties in assessing eligibility.** Not only are the 2007 criteria very high level, it is inherently difficult to judge someone's need over the phone and there are plenty of grey areas in transport need.
- **Lack of transparent and consistent data on activity, KPIs and costs,** hindering planning and accountability, leading to poor commissioning and contracting.
- **The lack of capacity and expertise required to develop, monitor and manage the relatively complex contracts required for NEPTS** – as a service which represents less than 0.5% of NHS spend, it can be hard for commissioners to prioritise such capacity.

### 3.3 Challenges in reaching net zero

As noted in section 2, NEPTS and the HTCS is estimated to constitute around 20% of NHS travel emissions, around 57,000-65,000 tonnes of carbon dioxide equivalent each year.

The NHS has set out an ambitious roadmap to **eliminate emissions**:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 – NEPTS is included in this target – we are committed to transitioning the NHS fleet to zero-emission vehicles.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 – HTCS, reimbursement and other transport support contributes to this target.

The net zero targets apply to all NEPTS contracts directly commissioned by the NHS, whether delivered by the NHS or by independent providers. This will require

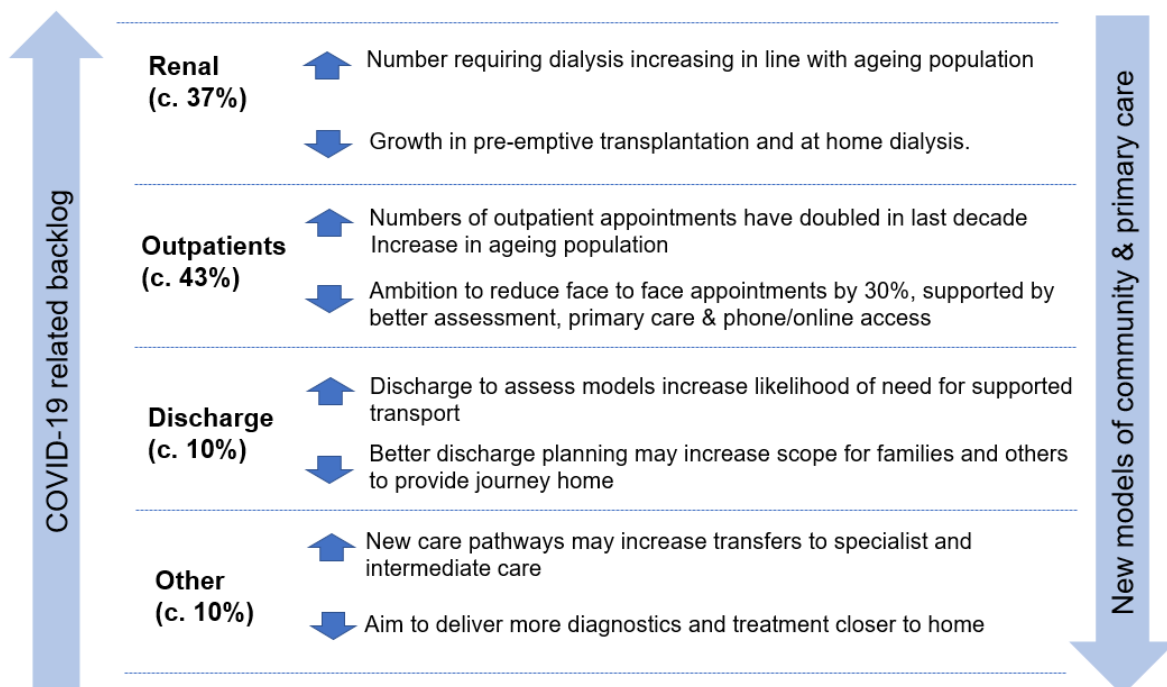
significant change: combining new vehicles, new infrastructure and where necessary adapting delivery models to the new opportunities and challenges of charging. The NHS net zero plan recognises that ambulance technology is earlier in development than other vehicles, and is pioneering innovation and testing of several fully electric ambulances.

More widely, signposting and facilitating access to public and other group transport which is more sustainable will need to be an important element in reducing the overall emissions from patient transport.

### 3.4 Uncertainty in demand

These challenges will need to be met in the context of significant uncertainty around demand. Many providers reported increasing demand and more complex patient needs before the pandemic and a significant recent rebound as treatment services have been restored. New models of care could also reduce demand in the medium term (see Figure 5).

**Figure 5: Factors increasing and decreasing demand, 2021-25**



What is almost certain is that the range of settings in which healthcare is delivered is likely to continue to diversify, and so is the need for flexibility. The model of a small acute hospital providing nearly all complex diagnostics and secondary care in

a locality – which formed the basis for traditional models of NEPTS – continues to evolve. More routine diagnostics and treatment is anticipated to be provided by groups of primary care practices, while the acute sector is set to become even more collaborative in the provision of specialist care across an ICS. The need for more flexible discharge is growing. These developments are likely to **increase the need for more tailored transport and impact the locations to which patients are being transported.**

For the HTCS, the economic position and therefore numbers on low incomes entitled to support, is equally uncertain. The number of households claiming Universal Credit has almost doubled over the period of the COVID-19 pandemic, which could lead to increased demand for HTCS. However, awareness of and appropriate accessibility to the scheme are likely to be more significant determinants.

### 3.5 Opportunities

These challenges and uncertainties are matched by unprecedented technological innovation and the prospect of greater cross-healthcare collaboration.

#### **Better co-ordination and brokerage**

Over the last few years, the co-ordination of transportation has been transformed.

- Digital planning tools which draw from multiple journey information sources enable people to plan and carry out more integrated journeys across both public and private transport.
- Digital platforms are enabling greater utilisation of vehicles allowing greater productivity and value for money.<sup>52</sup> Digital co-ordination is also stimulating new models of demand-responsive transport, providing flexible point-to-point services alongside more established public transport services.
- Car ownership continues to increase and is still the preferred form of travel for most patients, but taxis and private hire availability is growing faster; up from around 200,000 vehicles in 2005 to nearly 300,000 in 2020, although

---

<sup>52</sup> [https://www.ucl.ac.uk/consultants/sites/consultants/files/maas\\_car\\_study\\_january\\_2018.pdf](https://www.ucl.ac.uk/consultants/sites/consultants/files/maas_car_study_january_2018.pdf)



concentrations are over twice as high in urban areas compared to rural areas.<sup>53</sup>

These developments, together with the environmental imperative to change to electric vehicles and the long-term prospect of autonomous vehicles, is leading many people to expect an evolution to 'mobility as a service' in the medium term, at least in cities. There is a prospect that more people will seek to purchase journeys in the most convenient form, rather than rely on one vehicle they own.

Patient transport around the world is already benefiting from such co-ordination technology. In the US, for example, the largest patient transport co-ordination systems now work across multiple cities, drawing on an enormous diversity of provision to meet different needs. One draws on over 5,000 different providers of transport and is fully integrated with taxi platforms.

Similarly, in the UK a number of platforms are being developed. For example, in the North West an active digital taxi marketplace has been introduced designed to reduce journey length for patients, deliver unit cost reductions and improve productivity. Fifty taxi suppliers have been onboarded onto the platform and the platform provider reports that prices have fallen by between 5-10%.<sup>54</sup>

The scope for better co-ordination and communication is not confined to large dedicated platforms. Of around 130 suggestions made to the review for innovation and the application of good practice, nearly half covered booking and tracking, co-ordination and patient communication.

---

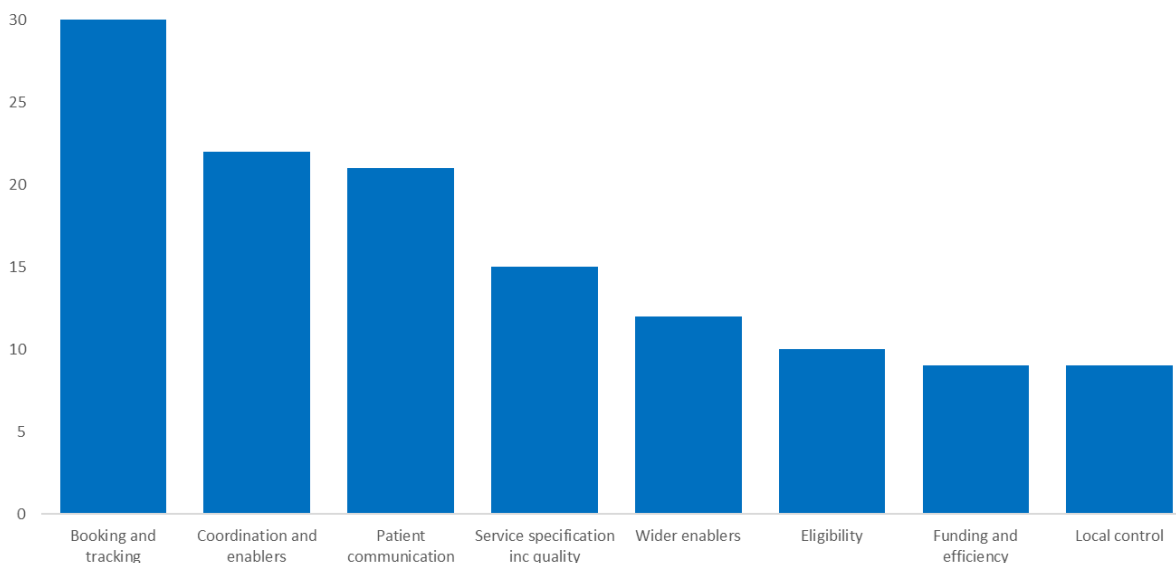
<sup>53</sup> DfT Taxi statistics:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/944680/taxi-and-private-hire-vehicle-statistics-2020.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944680/taxi-and-private-hire-vehicle-statistics-2020.pdf)

<sup>54</sup> Information provided to the Non-Emergency Patient Transport Review by 365 Response.



**Figure 6: Suggestions of good or innovative practice, by theme**



## Pathway improvements

The NHS is seeking to transform the way in which traditional outpatient services operate. This involves better assessing when people need follow-up appointments, offering greater use of video and telephone appointments, and allowing primary care to manage more conditions through enhancing specialist advice and guidance to general practitioners. We expect that these will reduce the need for face-to-face appointments by 30% by 2023/24 compared to 2019/20. Between March 2020 and March 2021, more than 22 million virtual outpatient appointments have been delivered, leading to faster and increased access to care for patients, increases in air quality and potential carbon savings of 111 ktCO<sub>2</sub>e across all types of patient journey.

This should free up NEPTS capacity currently used for some outpatient appointments, allowing other groups to make greater use of NEPTS and enhancements in quality.

Alongside outpatient transformation, a number of other pathways are developing rapidly; changes which have often been accelerated in response to the COVID-19 pandemic:

- Hospital discharge has been enhanced to help people return to care closer to home more rapidly, with more rapid 'discharge to assess models' and investment in discharge teams.

- Diagnostic services are being developed closer to home – through community diagnostic hubs.
- Renal patients are increasingly being offered home haemodialysis, where they are able and willing to carry out their own treatment with input from a home dialysis team.

There is opportunity to embed better approaches to travel within these new models of care.

### **Strengthening integrated care**

The partnerships required to deliver high-quality, and innovative, patient transport could also be enhanced by the Government proposals for strengthening integrated care from April 2022.<sup>55</sup> Backed by legislation expected in the coming months, this should help:

- Enhance collaboration between healthcare providers – which could underpin better planning and delivery transport in areas and integrate transport with care pathways.
- Stronger partnerships in local places between the NHS and local authorities – the Government proposals envisage particular collaboration around discharge planning, and there is scope to explore how platforms for non-specialist transport can cover health, social care and education.
- Taking a more pragmatic and flexible approach to procurement, and allowing commercial expertise to be used where it is needed more.

---

<sup>55</sup> DHSC, 2021 Integration & Innovation: Working together to improve health and social care for all

### Box 3: Integrated transport

In Devon, the CCG and local authority have well-developed working relationships (through a s75 agreement) and transport teams are co-located to enable continued collaboration. Budgets are in the process of being shared virtually between health and social care to enable a more joined up approach to non-emergency transport generally. Enquiries are received from provider trusts including A&E, patient direct requests, HCP requests, GP requests, and renal/oncology units.

- A centrally coordinated patient transport advice service (PTAS) assesses eligibility for transport and books appropriate journeys through the PTAS provider or other accredited providers. PTAS also receive and assess requests for repatriation funding to get value for money for the CCG.
- Patients found not to be eligible: the requester is advised of existing accessible public transport links or asked to make contact with the local Community Transport scheme. The local Community Transport team then provide information, advice and help book alternative transport at the patient's cost.

PTAS was originally funded by a successful bid to the Department for Transport as part of the Total Transport pilot project aimed at integrating transport services across the public sector.

### Adapted and sustainable vehicles

A rapid transformation of the transport sector is occurring across the country, with the NHS already adopting ULEVs and ZEVs across our fleet for delivery of care and logistics travel. As part of the Government's 10-point plan for a 'green industrial revolution' the UK will cease the sale of new combustion-engines by 2030, and will also end the sale of new hybrid cars by 2035.<sup>56</sup> In addition, the adoption of Clean Air Zones and Ultra-Low Emission zones in urban centres is expected to increase over the coming years.

---

<sup>56</sup> [Government takes historic step towards net-zero with end of sale of new petrol and diesel cars by 2030 - GOV.UK](https://www.gov.uk/government/news/government-takes-historic-step-towards-net-zero-with-end-of-sale-of-new-petrol-and-diesel-cars-by-2030) (www.gov.uk)

Taxis, and to a lesser extent, private hire vehicles are also adapting to an ageing population, and long-held demands of people with a disability. Nearly seven out of 10 licensing authorities now require taxi providers to provide all or some vehicles which are wheelchair accessible. Nearly half of all taxi drivers undertake disability awareness training.<sup>57</sup>

In a similar way to overcoming the challenges, realising these opportunities relies on improvement in systemic factors: enabling investment; stimulating innovation and enabling market entry; strengthening relationships; and stimulating the sharing of learning.

### 3.6 Learning from the COVID-19 response

Patient transport providers and staff have gone to extraordinary lengths to adapt and respond to the challenges of COVID-19, like their partners and colleagues across the health and care sector.

**Co-ordination.** NHS Ambulance Service providers co-ordinated NEPTS resource and managed capacity in their geographical footprint, including by working very closely with independent and voluntary sector providers to understand and share capacity.

**Responsiveness.** New models of personalised transport were introduced to comply with social distancing requirements of no more than one or two patients in any vehicle. Patients needing discharge or transfer from a care setting, where no other means of transport possible were managed to new national standards of transport, with an ambition of transport within one hour.

**New forms of partnership and diversity of suppliers,** with a particular focus on maximising capacity across numerous providers at peak times, and traditional contractual approaches replaced with more collaboration and redeployment to support emergency services.

**New civic engagement.** Although around three million people formally or informally volunteer in providing transport generally, healthcare schemes have reported

---

<sup>57</sup> It should be noted that whether these developments extend to growing private hire platforms will be important to the opportunities for an inclusive transport system – according to latest government figures, there are around 40,000 wheelchair accessible taxis but only 5,000 such private hire vehicles.

struggling with volunteer recruitment and retention. The response to COVID-19 has highlighted the way in which goodwill and interest can be harnessed and co-ordinated, including through around 2,000 patient journeys being provided each month arranged through the GoodSAM app.<sup>58</sup>

Implementing these changes has come at organisational cost and required significant commitment by staff. They have not always been smooth. However, they point to important improvements which could be sustained and built on in the future.

#### Box 4: Collaboration in response to COVID-19

During the COVID-19 pandemic, NHS providers and independent NEPTS providers worked across contractual boundaries to support each other and share capacity across their vehicles. For example:

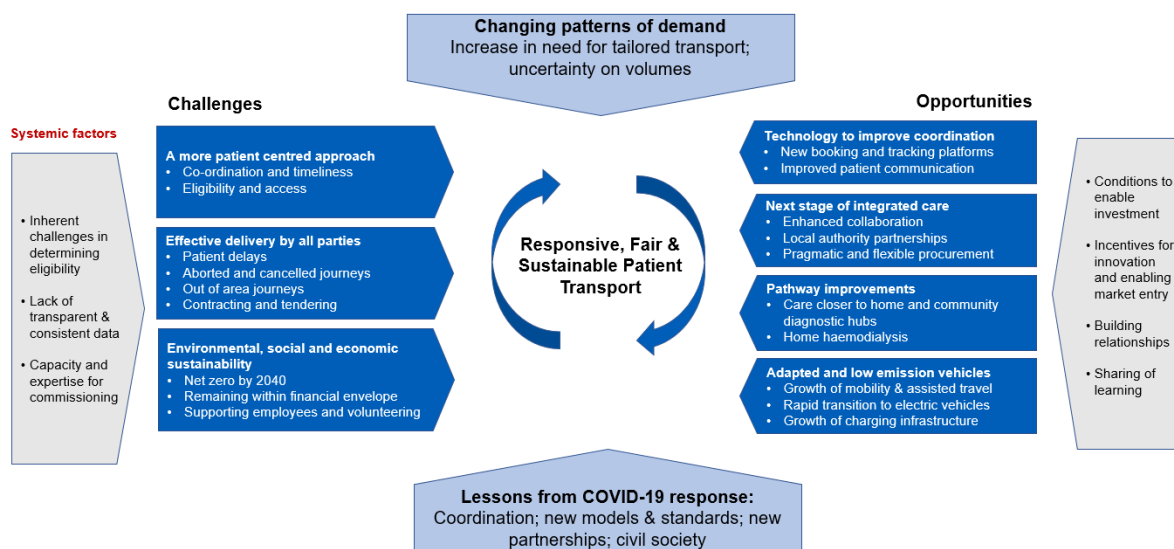
The London Ambulance Service, despite no longer delivering services, took responsibility for strategic co-ordination of NEPTS across the capital during the pandemic. A number of providers have highlighted to the review the valuable role they played.

ERS Medical launched a patient transport planning tool to help commissioners and procurement managers across the country understand the impact of COVID-19 on patient transport requirements and resourcing considerations. They bolstered services to provide transport for patients with suspected or confirmed COVID-19, in a way which one of the ambulance services described as 'true partnership working'.

---

<sup>58</sup> NHS Volunteer Responders data

**Figure 7: Challenges and opportunities**



## 4. Objectives

The evidence shared with this review, and opportunities and challenges in the years ahead, define three major objectives for non-emergency patient transport. It needs to be more consistently **responsive, fair and sustainable**.

### 4.1 Responsive

Despite good practice and hard work by commissioners, providers and staff, there are still far too many examples of patients being expected to conform to the transport system rather than the system being designed around patients; and some instances of transport being poor quality.

Patients at hospital can wait two hours; when in most of the country, shoppers can expect a taxi within 15 minutes. People on very low incomes seeking a few pounds of reimbursement from the HTCS who make a central claim may wait up to 90 days, when most electronic transactions now take less than nine seconds. While the objective of people sharing transport is welcome, an assisted taxi may be more convenient for the patient and better value for money for the commissioner than the traditional NEPTS minibus.

Managing transport for people with medical conditions is clearly more complex than generic transport provision. However, there is opportunity to harness technology,

communications and collaboration to do consistently better. The sector's response to COVID-19 has also demonstrated some of the potential for more personalised and flexible approaches. Delivery models evolved incredibly rapidly. More journeys were provided individually. Reimbursement has grown in use. System-wide co-ordinated improved new relationships formed with non-specialist providers.

The task for the coming years is to maintain and enhance such responsiveness. NEPTS needs to be consistently safe, high-quality and patient-centred: minimising waiting times, keeping people informed, better integrating transport into the treatment pathways and where possible giving people more control.

## 4.2 Fair

NHS transport support is for those people whose medical condition makes independent travel impossible or unsafe, or for who are on such a low income as to make transport unaffordable. That is the same in nearly every country.

It is right that local areas have a say in determining which patients receive support. The expectations on independent travel for those with a mobility constraint may be understandably different in, for example, London where every black cab is a wheelchair accessible vehicle and accessible public transport plentiful, compared to rural Cumbria where even standard private hire vehicles may be difficult to book and bus routes very sparse. It is also right that some discretion is given to clinicians and others making difficult decisions on who needs support and who can manage independently.

However, when someone with a very similar need is provided support in one area but their patient support group peer a few miles away has no help, this understandably causes frustration. Likewise, patients should expect common core safety and quality standards irrespective of the area or provider.

Over the next few years, greater consistency is therefore needed to help the NHS and patients fairly navigate these complicated assessments of need, while continuing to allow local adaption and, ultimately, clinical discretion. Alongside this, the HTCS needs to become more accessible, and patients should expect to be provided with some signposting to independent transport should they need it.

## 4.3 Sustainable

Non-emergency patient transport needs to play its part in delivering the NHS's ambitious commitment to a net zero health service by 2040. Transitioning services to net zero-emissions will also have a direct effect on reducing the harm to human health that air pollutant particulates from petrol and diesel vehicles contribute to.

The growing availability of electric vehicles at the same cost price as comparable combustion vehicles over the next decade, and the growth in public electric vehicle charging infrastructure offers scope for adoption and innovation. However, this wholesale shift will require significant change and a commitment from providers.

Patient transport will need to achieve this goal, alongside greater responsiveness and more consistent eligibility and access, during a period of significant resource pressure. That is why the terms of reference for this review set out an ambition to achieve improvement broadly within current envelope of funding.<sup>59</sup>

Contributing to economic and social sustainability also rests in how the NHS uses these resources. To improve productivity, services need to maximise the utilisation of vehicles and invest in their staff. We can also forge deeper partnerships with communities; although for some years now, community transport has been under pressure from reductions in local authority funding and changing regulations.<sup>60</sup>

Over the next few years, the patient transport system needs to therefore stimulate and effectively manage innovation and investment to achieve emissions reductions, value for money, good jobs and, deeper relationships with communities.

# 5. A new national framework for non-emergency patient transport

The diversity of patients' transport needs, varying local contexts, and a rapidly changing technological landscape all mean that it is not appropriate to mandate a single, detailed operational blueprint for all non-emergency patient transport.

---

<sup>59</sup> <https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/nepts-review/>

<sup>60</sup> <https://ctauk.org/wp-content/uploads/2018/05/State-of-the-Sector-England.pdf>



However, such local planning should be underpinned by a national approach which incentivises person-centred service delivery, raises minimum standards of access and delivery, and provides a foundation for investment and innovation by providers and commissioners.

Over the next two years, NHS England and NHS Improvement will therefore establish a new **national framework for non-emergency patient transport**. The framework has five core components:

- i. Updated national guidance on eligibility for NEPTS
- ii. More accessible transport advice and support for patients more widely
- iii. Greater transparency on activity and performance
- iv. A clear path to net zero patient transport
- v. Better procurement and contract management.

These will be introduced alongside wider measures to reduce the need for people to travel to hospital outpatient appointments, develop more local diagnostics, introducing free car parking for those who need to frequently attend hospital and decarbonise the NHS fleet.

The role of ICSs will be to combine this framework with effective and collaborative local service planning and innovation, listening to the voices of patients and integrating transport more closely into wider pathway improvements.

## 5.1 Updated national guidance on eligibility

To respond to patient requests for greater consistency, and allow transport providers and commissioners to develop more common standards, NHS England and NHS Improvement will publish updated national guidance on eligibility.

The updated guidance will maintain the principles of the previous DHSC 2007 guidance.

The core proposed elements of this guidance are enclosed in a consultation launching alongside this report. They will be subject to a public consultation from

August to October this year and we anticipate will be available for use from April 2022.

We will consult on the timescale for adopting these criteria, but currently we expect that they will be reflected in services planned and tendered from April 2022. We also expect established services and eligibility assessment processes to reflect these criteria from April 2023.

Our proposals are to:

### **1. Clarify eligibility for core patient groups**

The revised criteria aim to provide clarity that specialist transport, with suitably trained staff, should be provided for those who:

- have a medical need for transport
- have a cognitive or sensory impairment requiring the oversight of a member of patient transport staff or suitably trained driver
- have a significant mobility need which cannot be met through public or private transport, including the support of available family or friends or a taxi
- have a safeguarding concern raised by a relevant professional in relation to them travelling independently.

This element is in line with previous national guidance from DHSC, but provides further detail to ensure greater consistency. For example, they set out the common types of mobility need which would usually entitle patients for support.

The more detailed common criteria should, in turn, allow more the development and sharing of best practice in assessment approaches across England. While it is not for NHS England and NHS Improvement to stipulate the exact questions used, we will use new improvement networks and greater transparency will enable a converge of assessment practice alongside the more consistent criteria themselves.

### **2. Introduce a universal commitment to transport support for all journeys to and from renal dialysis**

As noted previously, in-centre haemodialysis results in a significant and long-term transportation burden which substantially impacts on a patient's quality of life and health. The NHS should empower and support every patient to manage these journeys.

We know that in some parts of the country waiting times are unacceptably long or uncertain, and transport is not always appropriate, while other patients provide positive feedback. The research for this review also reinforces how different patients receiving dialysis often want different transport options, and at different times, depending on their health and personal preferences: sometimes specialist transport, sometimes taxis and sometimes driving themselves.

We will therefore introduce a **universal commitment to transport support for all journeys to and from in-centre haemodialysis**. Such an approach is already common in many parts of the country but not all, and our surveys indicate that around a third of dialysis patients currently receive no transport support.

The universal commitment involves access to either:

- Specialist transport, when adapted vehicles or staff with particular training is required
- Non-specialist transport, when people need less support
- Simple and rapid reimbursement for the cost of journeys where people are able to drive themselves, their family or friends can take them, or they can use public transport, including any car parking charges not covered by the existing free car parking commitment.

The appropriate type of transport should be a shared decision, reflecting people's needs and preferences as well as the appropriate use of NHS resources. Patients should be empowered and supported to retain their independence and a personalised approach should be promoted.

Our survey of over 60 dialysis units indicates that about 30% of patients are likely to require specialist transport, 40% non-specialist transport and 30% are likely to be able to travel independently if appropriately reimbursed. However, an individual's needs will vary over time and so flexibility is required to ensure that patients can level up or down the degree of support needed. Reassessments of need should be in line with a shared decision-making approach.

## Box 5: Measuring the effectiveness of the universal commitment

We will measure the effectiveness of this universal offer through monitoring and publishing specific performance information on journeys for renal patients including:

- Average waiting times
- A measure of long waits
- Other patient-focused performance metrics in the new minimum data set.

A success criterion for the review implementation will be that average waiting times for renal patients should be lower at the end of the implementation period than today. We asked dialysis units for a high-level average waiting time as part of our survey and found the average waiting time to be around 45 minutes, but the range varied from 15 minutes up to 90 minutes for several units.

The implementation team and evaluation will also contain a specific element on identifying and disseminating best practice on shared decision making for renal patients. These specific measures fit within the broader measures for accountability, minimum standards, transparency and journey choice which will support all patients including renal patients.

### **3. Reinforce the assumption that those with less significant mobility needs should travel independently**

Patients who do not meet these core criteria should use their own transport, support from a family member or friend, public transport and taxis/private hire vehicles.

However, in the event that no other transport is suitable or available, the draft guidance includes the scope for eligibility assessors, at their discretion, to offer access to transport if treatment or discharge are likely to be severely delayed. It also gives discretion to local areas to support those whose transport burden is higher due to journey frequency, length or costs.

As part of the introduction of the guidance, NHS England and NHS Improvement will look to share best practice on these eligibility assessment processes, including

where clinical judgement is considered as part of the criteria, during the Review implementation period. There are difficult choices to make regarding borderline needs and an element of judgement is always going to be necessary within a national framework.

## 5.2 More accessible advice and support for patients

The extensive community consultation by Healthwatch and work by Age UK and others highlights the value of good transport to health treatment more generally, not simply NEPTS.

While primary responsibility for local transport sits with transport authorities, the NHS has a role to play in facilitating good journeys.

### **Improving access to the HTCS**

As noted in previous sections, the vast majority of people who may be eligible for help with their travel costs are probably not aware of the HTCS. The system for reimbursement is often cited as confusing and complicated. Reimbursement can take up to 90 days in some instances due to the numerous bodies involved in verifying eligibility, processing each claim and issuing the reimbursement.

The NHS will therefore work with DHSC to significantly streamline, simplify and speed up access to reimbursement through the HTCS.

Through a detailed patient-focused service redesign, we:

- anticipate that this will involve a simplified access process, where possible aligned to co-ordination, management and reimbursement mechanisms for those eligible for NEPTS to ensure that the maximum time for processing claims will be reduced from 90 days to no more than 30 days, and far shorter if possible.
- will support this improvement by more closely integrating the management of the HTCS into wider transport support and co-ordination, which we anticipate will include a single budget for NEPTS and HTCS at ICS level.

We will seek to implement these changes as rapidly as possible, subject to work with DHSC to amend the regulations underpinning the HTCS<sup>61</sup> and work with NHS BSA to streamline their assessments of qualifying benefits. We therefore expect the changes to maximum processing times to be implemented by the end of 2023 at the latest, with more local integration improvements to be made sooner.

Recognising that simplifying this scheme could introduce some risks of fraud or abuse, we will work with the NHS BSA and the NHS Counter Fraud Authority to introduce a mechanism of audit which ensures only those eligible for HTCS are able to successfully make claims. Improved real-time data sharing between the NHS BSA and the Department for Work and Pensions will help with clarifying eligibility status and in doing so reduce the likelihood of falsified claims being reimbursed.

### **Increasing the availability of information on travel options**

Good local healthcare providers already offer patients information and guidance on travel options to treatment. The draft national eligibility guidance includes an expectation that, as a minimum, all patients who enquire about transport support should be provided with details of independent transport options including public transport, taxis and community transport.

At a minimum we expect that this will include providing easily-accessible information on journey options. We recommend that trusts should also consider employing a transport co-ordinator if they do not already do so, or enable co-ordination centres to provide details to patients looking for advice. There is also an opportunity to link with the increasing number of electronic platforms which enable people to better plan transport routes.

In due course we expect that such automated transport planners will enable people to assess the CO2 emissions generated by different options.

### **Enabling access to community transport**

Throughout the review we heard of how valuable people often find community transport to be. The involvement of volunteers and links with voluntary sector

---

<sup>61</sup> The National Health Service (Travel Expenses and Remission of Charges) Regulations S.I. 2003/2382

organisations can help integrate transport with people's wider social and wellbeing needs (see Box 6).

## Box 6: Voluntary sector Take Home and Settle services

Many local and national voluntary sector organisations (such as the British Red Cross, Age UK and the Royal Voluntary Service) provide take home and settle services providing transport and initial support for people leaving hospital with limited or no support available from family or friends.

As an example, the British Red Cross are currently working with over 100 trusts, providing services 7 days a week. Pre-COVID-19, some 20,000 annual journeys were supported through a mix of volunteer and paid drivers, rising to over 50,000 during the pandemic plus 39,000 ambulance journeys.

In some contracts they are part of the discharge team. In others, they provide transport, eg for renal patients. Drivers are provided necessary training, such as basic first aid, safeguarding, compassion and interpersonal skills.

The review implementation programme will therefore include measures to stimulate the contribution of community transport both as a wider transport option for patients not eligible for NEPTS and as an element of non-specialist NEPTS provision for patients who are eligible. This includes volunteer driving schemes, and ride sharing.

Based on initial engagement, we expect that this will focus on:

- Using the ability of the NHS to regularly engage with the public to help facilitate recruitment of additional volunteers and support their progression into longer term volunteering opportunities. As part of this, we plan to harness the local and national infrastructure for health-related volunteer recruitment developed during the pandemic. This will include learning from successful engagement approaches at trust-level with local community transport services and supporting the longer-term commitments of volunteer drivers who have volunteered through the GoodSAM app.
- Supporting volunteer training and ongoing development.

- Exploring opportunities for integrating community transport better into local co-ordination platforms – which is easier to facilitate if these are shared or at least linked up with local authority platforms.

We anticipate that these developments to improve the HTCS and community transport will be designed and tested in partnership with three areas (ICSs or localities). This development will take place in 2022 and 2023.

### 5.3 Transparency to incentivise responsiveness and enable learning and accountability

To enable and incentivise improvement, timely, comparable and meaningful information is required at a local and national level. In particular, it is important to assess the responsiveness of services to patient needs and aspirations.

Core information on NEPTS activity and performance is not available nationally, regionally or in many local areas today. As a consequence, commissioners often have insufficient understanding of activity and comparative performance, hindering management and effective contracting. Providers often have to bid for contracts with limited information on estimated journey volumes and activity. NHS England and NHS Improvement are unable to identify good practice, problems or inconsistencies. And, most importantly, it is hard for the public to hold the NHS to account.

We want to make key information on system activity and impact more transparent, and ensure performance is measured in a balanced way. To achieve this, we will introduce recommended best practice activity measurement, including suggested domains for KPIs, to be adopted at a local level to allow more consistent monitoring and management of services, as well as improved contracting.

In addition, we will expect systems to report on some of these elements as part of a published national minimum dataset.

#### **Best practice guidance on the local recording of activity and performance**

To support a consistent assessment of performance, we will publish recommended activity measures under a series of domains linked to our overall objectives. These will not be mandatory for commissioners to include in contracts, but aim to provide



a foundation for comparison between areas and to streamline reporting for providers who operate in multiple areas. The aim is to reflect the balance of success measures for NEPTS, rather than skew provision with a focus on just one or two metrics.

These measures will be developed with the patient transport sector and patient groups. Initial proposals are published for discussion alongside this report on the FutureNHS collaboration platform.

**Table 2: Example domains for activity and performance monitoring**

Objective	Domain
1. Responsiveness	1.1 Patient satisfaction, communication and safety
	1.2 Co-ordination and integration
	1.3 Journey quality and timeliness
2. Fairness	2.1 Service use and health inequalities
3. Sustainability	3.1 Environmental sustainability
	3.2 Financial sustainability

## A national minimum dataset

Centred around the same domains described above, a national data collection process will be introduced, conducted twice annually.

The initial focus will be on the collection and reporting of data that provides oversight into the core operations of services. This will include the most important comparative metrics and indicators from the recommended local activity measures.

Example activity measures and indicators for the national minimum dataset under the domains described above include:

### 1.1 Patient satisfaction, communication and safety

Example measures:

- a measure of patient satisfaction, including patient communications – assuming a robust national measure is feasible such as the patient transport Friends and Family Test.

## 1.2 Co-ordination and integration

Example measures:

- number of patients deemed eligible as a proportion of requested bookings
- number of patients referred to HTCS/other forms of transport/reimbursement schemes.

## 1.3 Journey quality and timeliness

Example measures:

- patient waiting and journey times, including a measure of long waits
- journey volumes.

## 2.1 Service use and health inequalities

Example measures:

- reason for the journey, such as outpatients, renal or discharge
- patient needs and characteristics.

## 3.1 Environmental sustainability

Example measures:

- proportion of vehicles which are ultra-low and zero emissions.

## 3.2 Financial sustainability

Example measures:

- ICS expenditure per capita.

These measures will help to allow monitoring of performance by journey type and/or patient cohort.

While we would expect most of the data would be for providers to report on,<sup>62</sup> we recognise that NHS ICS bodies would need to report on the overall expenditure, incorporating not only transport provision and co-ordination spend, but also spend on the HTCS and reimbursements.

A more detailed proposal for this minimum national dataset is being published alongside this report on the FutureNHS collaboration platform as a discussion paper. We will work with NHS Digital, providers and ICSs to refine and agree this dataset over the next few months with an intention to publish the finalised domains

---

<sup>62</sup> We expect that commissioners will use the service conditions of the NHS Standard Contract to ensure providers share data to inform submissions to this national dataset.

and measures by March 2022 so that the first tranche of national data can be published by the end of 2022.

## 5.4 A clear path to net zero patient transport

The NHS is committed to net zero and therefore is committed to using a fully zero emission fleet across all operations. NHS England and NHS Improvement expect the NHS as a whole to have a fully zero emission fleet ahead of the NHS commitment to become net zero by 2040.

That ambition is shared by the NEPTS sector. As part of the review, we have specifically engaged with NEPTS providers on achieving net zero and assessed the wider context of government policy and likely vehicle costs. Providers all expressed a commitment to decarbonisation. Many transport providers have already begun their decarbonisation journey, sometimes prompted by local authorities' Clean Air Zones but also by the lower operating cost of zero emission vehicles.

Providers have asked for more certainty on timescales to enable fleet planning.

Our ambition is that all NEPTS vehicles, with the exception of ambulances and volunteers using their own vehicles, should be zero emission by 2035, irrespective of contract duration. However, early action will be required to ensure a gradual decarbonisation of the NEPT service fleets. The following NEPTS transitional trajectory, as seen in the table below has been agreed and will apply to all NEPT vehicles, with the exception of ambulances, and apply to contracts issued or renewed after the set date.<sup>63</sup> A 2035 transition date will apply irrespective of contract duration.

---

63

**Table 3: NEPT vehicle decarbonisation timeline**

Date	Vehicle emissions targets
From 2021	No immediate changes
From 2023	50% of vehicles used to deliver the contract are of the latest emission standards, ULEV or ZEV
From 2026	75% of vehicles used to deliver the contract are of the latest emission standards, ULEV or ZEV
From 2030	100% of vehicles used to deliver the contract are ULEV or ZEV, including minimum 20% ZEV
<b>2035</b>	<b>100% of vehicles used to deliver the contract are ZEV</b>

Targets will be applied to the overall contract or lead provider, thus an aggregate proportion of all vehicles planned to be used as part of the service should meet the targets. Commissioners should ensure that an aggregate proportion of all transport providers for NEPTS on dynamic purchasing frameworks also comply with the targets.

At a later date, NHS England and NHS Improvement will set out plans for when it expects all ambulances to be zero emission; NEPTS providers will need to comply with future plans for ambulances and this will be reflected in further guidance and standards.

Several of the key actions listed throughout this report, such as data collection, core standards, contract length, and collaboration across geographies, will be key enablers for achieving these ambitions. We are committed to working closely with the sector to support this transition. Further engagement after the review's publication will continue to refine how these enablers deliver the 2035 target.

While progressing rapidly, the technological capability required for zero-emission ambulances is still in development, and a decarbonisation trajectory for ambulances is also in development by NHS England and NHS Improvement, but out of the scope of this review. These plans will be reflected in future guidance and standards. To support the development of zero emission ambulances, two of England's Ambulance Services are developing zero emission emergency ambulances, the London Ambulance Service and the West Midlands Ambulance Service.

These ambitions are currently projected to be cost-neutral to the NHS, under the assumptions that:

- a. The cost of purchasing and leasing zero-emission vehicles will fall over the next decade, expected to reach cost parity with internal combustion engine vehicles by 2030 or earlier.<sup>64</sup>
- b. Financial savings will be generated by lower fuel and maintenance costs associated with electric vehicles, as per Department for Transport's long-term projections.<sup>65</sup> Due to fuel cost savings, there is a net financial benefit to NEPTS providers to transition their vehicles to electric vehicles (EV) as soon as they are able to do so.<sup>66</sup>
- c. Government expansion of public electric vehicle charging infrastructure will create one of the best electric vehicle infrastructure networks in the world,<sup>67</sup> supported through investment in charging infrastructure by healthcare providers, where appropriate.

Under these assumptions, these emissions targets would result in a potential annual saving of **43 ktCO<sub>2</sub>e** by 2038, as well as a reduction in local air pollution levels. This will play an important role in contributing towards the Long Term Plan ambition of cutting fleet air pollutant emissions by 20% by 2023/24.

## 5.5 Improving procurement and contracting to incentivise responsiveness and sustainability

### Recognising the distinct elements of provision

As set out in Section 2, the patient transport system involves four core components: triage and co-ordination; specialist services; non-specialist services; reimbursement. Planning needs to also consider relationships with improving integrated patient pathways, such as discharge, and the wider transport system, including urgent services and local authority provision. All these components may be provided by a single provider; or a lead provider who sub-contracts.

---

<sup>64</sup> Analysis by the Committee on Climate Change suggests price parity will be achieved by 2030, whereas Bloomberg New Energy Finance predicts it will be between 2025-2027.

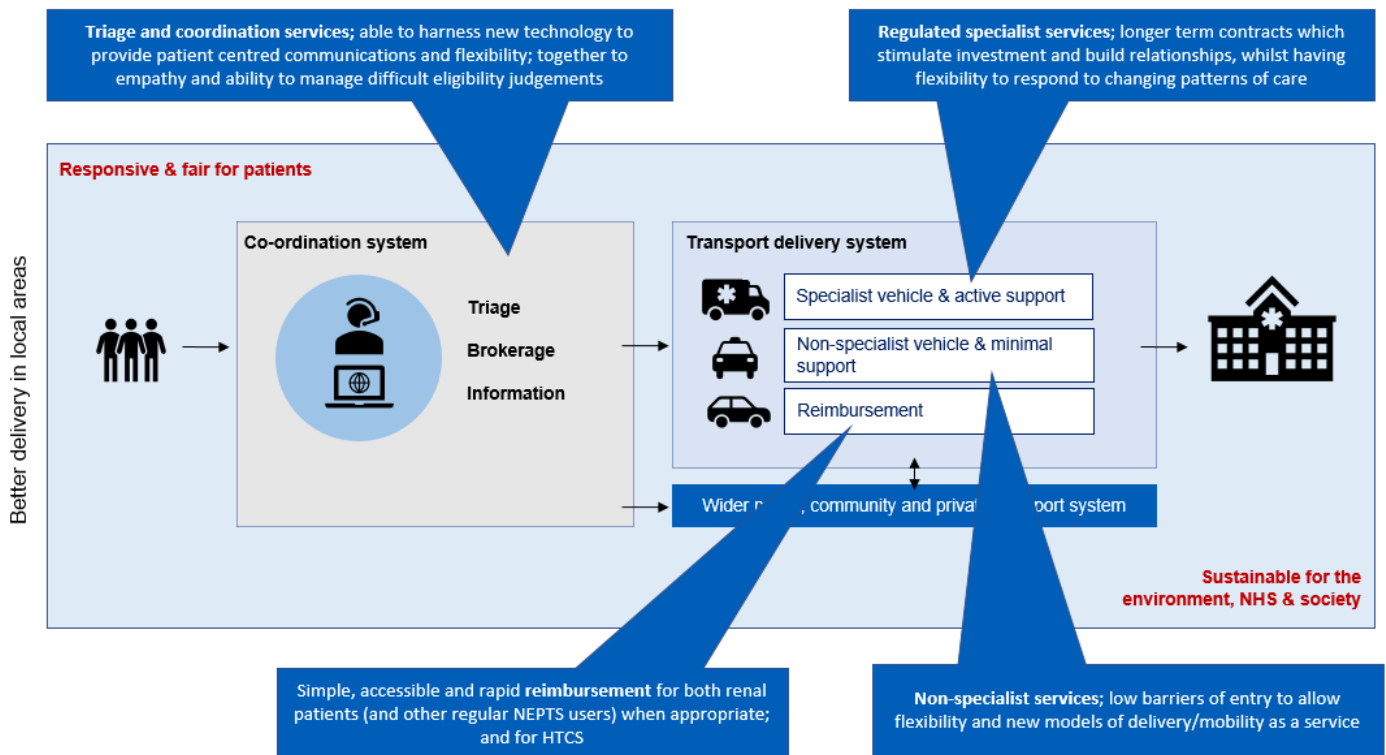
<sup>65</sup> <https://www.gov.uk/government/publications/tag-data-book>

<sup>66</sup> Greener NHS team modelling using DfT data

<sup>67</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/739460/road-to-zero.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/739460/road-to-zero.pdf)

Alternatively, areas may decide to split these elements in recognition that the marketplace and nature of contracts for each may vary.

**Figure 8: Distinct services and implications for procurement and contracting**



Whichever arrangement is most suitable, good commissioning, procurement and contracting should recognise the different forms of expertise, experience, payment and contractual conditions associated with each:

**Triage and co-ordination.** Commissioners should consider how a single point of co-ordination and brokerage for NEPTS across an ICS or other geographical/provider footprint could improve patient experience and equity of access. They should consider which elements can be enhanced by co-ordination technology to increase responsiveness, fairness, sustainability (through route planning) and productivity (through vehicle and driver utilisation). Usually this will also act as the mechanism for decisions on eligibility. There can also be benefits from economies of scale and links with 999 services, some areas already have integrated call handling across 999, 111 and NEPTS.

**Specialist transport services.** Where providing specialist vehicles, trained staff, high levels of quality and safety reflected in being a CQC registered provider and long-term investment in specialist vehicles alongside the recruitment and training of the workforce and development of collaborative relationships are particularly important.

**Non-specialist transport services.** Where there is often greatest scope for new models of delivery, including multiple-use vehicles and providers, such as taxis, community transport, and volunteers. There is also scope to raise productivity of vehicles and providers by integrating with other transport sectors. Providers do not usually require CQC registration (dependent on the design of the vehicle). Developing payment mechanisms which promote responsiveness is particularly important.

**Reimbursement schemes.** Access, simplicity, and timeliness is particularly important for reimbursement.

## **Developing best practice in procurement and contracting**

Subject to the introduction and passing of the Health and Social Care Bill, it is anticipated that the current rules governing the procurement of healthcare services will be replaced with a new regime for arranging healthcare services, the NHS Provider Selection Regime.<sup>68</sup> We expect that the new regime will apply to commissioners when arranging for the provision of certain elements of NEPT services, such as those services subject to CQC regulation including specialist transport provision.

The NHS Provider Selection Regime is intended to give commissioners greater flexibility when making decisions around arranging healthcare services, including being able to select providers without conducting a competitive procurement in certain circumstances.

While decision-making bodies (such as NHS ICS bodies, subcontracting NHS trusts and foundation trusts) will be able to decide which approach is best, NHS England and NHS Improvement expect decision-making bodies to maintain a highly-developed understanding of the market for NEPTS provision, in particular in relation to quality and value, and the ability of providers to innovate, bring in new

---

<sup>68</sup> <https://www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on-proposals/>

technologies and respond to patient aspirations. Competitive tendering approaches will often be a helpful means of assessing this.

Therefore:

- During 2022, we will publish good practice guidance on procurement, and prior to that initial advice is set out below. Support will also be available from the national team.
- During 2022, we will also publish example service specifications - these will complement the new core standards, minimum data set and best practice KPIs.

This guidance and support will aim to ensure that the framework for distinct elements of NEPTS provision strikes a balance between the certainty providers need to invest in specialist vehicles and communication technology, and opportunities for the most innovative and high-quality providers to grow.

Prior to the service specifications and more detailed guidance being produced, we have set out initial recommendations below. These are designed to address the most significant challenges that have led to problems with procurement and contract management over the last few years. Most commissioners will already follow these principles. Alongside these points, we are engaging with the sector on more detailed proposals and best practice principles using a discussion paper on the FutureNHS collaboration platform. This discussion paper will form the basis for our further guidance.

NHS England and NHS Improvement now advises commissioners to follow these recommended approaches:

- a. **Contract value and payment models.** For specialist transport a fixed block value with clear mechanisms for variations on annual basis or ad hoc basis if fluctuations exceed certain thresholds. Contracts for most specialist services (ie those which do not involve only highly specialist vehicles) should span at least five years to enable core provider investment. This is particularly important when transitioning fleets to net zero.

For non-specialist transport, it is recommended that a framework agreement should be used to allow activity-purchasing from a wider pool of taxis, community transport and other local transport providers. Individual



reimbursement should be incentivised as an alternative where this offers value for money and personalisation. Commissioners should plan on the basis of the flexibility necessary to cover variations in activity which are an inherent element of providing responsive and fair patient transport.

- b. **Activity estimates.** Procurements should provide past activity and future estimates, broken down by patient volume and patient profile. As good practice, activity would normally include a breakdown of high-level patient need and previous transport/vehicle utilisation for at least the previous two years, and transparency on the assumptions behind any anticipated changes in demand.
- c. **Collaboration and engagement.** Procurement processes should involve key stakeholders notably including referrers to NEPTS eg acute trusts, mental health trusts and primary care to support design of services and KPIs. Specifications and contracts should enable collaborations between providers in delivering services, including lead provider models.
- d. **Procurement timescales.** The process for bidding for specialist services should be at least 60 working days and should be extended for very large contracts. Non-specialist frameworks should allow the regular assessment of potential new entrants and benchmarking of prices, using processes which provide sufficient time and clarity for a range of providers to seek to participate, including community transport, independent and SME providers and platforms.
- e. **Assessing bids.** Providers should be expected to demonstrate that their services offer the best possible value including considerations of price, access, co-ordination and integration, journey experience and timeliness, patient satisfaction and safety, sustainability and capacity. Prior to any comparatively low value bids being accepted, a financial review should be carried out to ensure the subsequent contract is sustainable.

### **Clearer core standards for specialist and non-specialist transport**

Core standards for NEPTS are currently dispersed across the NHS standard contract, CQC inspection standards and other legislative measures. Local contracts sometimes take different approaches. This has led to inconsistency for patients, and sometimes undermined safety. The CQC and others have also highlighted the

importance of appropriate regulation: ensuring clear standards for those providing a regulated healthcare activity while avoiding regulation where this is not required. It is important for commissioners to be assured that the relevant checks are being carried out to ensure regulated providers are being used for those services which require regulation. As part of this, commissioners will need to agree and clarify who will be carrying out these checks as part of local arrangements (ie is it the responsibility of the co-ordination body, the lead transport provider where subcontracts are in place or the commissioner).

Uncertainty also adds cost and complexity for providers needing to navigate various local arrangements. In other instances, innovative providers of non-specialist transport are excluded from serving patients with lower needs because the bar for all providers is set for those transporting those patients with significant medical risks.

By December 2022, NHS England and NHS Improvement will therefore look to clarify core elements of standards which are particularly relevant to NEPTS in the following categories:

1. Registration
2. Data
3. Workforce and training
4. Complaints
5. Communication
6. Emissions and other vehicle standards

These will sit alongside the proposed best practice service specification. They are not designed to duplicate measures in the NHS standard contract or CQC regulation. However, they should help distinguish between those standards which apply to specialist services for patients whose condition requires adapted vehicles and/or a member of staff with particular training and those which apply to non-specialist services where it is possible to rely on wider licensing arrangements.

To start that process, alongside this paper we are making available an initial discussion document for engagement with the sector on a new workspace on the FutureNHS collaboration platform. This will include recognition of the training and career pathway NEPTS provides into 999 ambulance service roles, as well as the

role standards will play as an enabler for transition towards net zero. It will also highlight the expectations of providers around NHS Emergency Preparedness, Resilience and Response.

We have also worked closely with CQC to ensure that CQC registration requirements are clearly understood (see Box 7). CQC welcome the introduction of the NEPTS core standards.

### Box 7: The role of CQC and registration for a regulated activity

CQC register, monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety.<sup>69</sup>

Providers are required by law to register with CQC if they provide any of the 14 Regulated Activities contained within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<sup>70</sup> NEPTS providers may therefore legally require registration for the Regulated Activity of Transport services, triage and medical advice provided remotely, if transport is by means of a vehicle which is designed or modified for the **primary** purpose of carrying a person who requires treatment.

Transport services provided in vehicles that have a different primary purpose (such as taxis, volunteers using their private cars, or mortuary vehicles and Dial-A-Ride vehicles) are not captured in this regulated activity, even though they may be registered with the Driver and Vehicle Licensing Agency as ambulances. Further explanation is available in the CQC Scope of Registration.<sup>71</sup>

## 5.6 Implementation

NHS England and NHS Improvement will continue to develop the actions in this framework in collaboration with ICSs, local authorities, providers of transport services, providers of healthcare, patient and civil society groups, trade unions and other stakeholders. That is why alongside this paper, we are sharing detailed

<sup>69</sup> [Regulations for service providers and managers](#)

<sup>70</sup> [The Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014, Schedule 1 9\(1\)](#)

<sup>71</sup> [CQC Scope of registration, March 2015](#)

proposals on key elements of proposed actions for consultation and feedback, to be followed by further engagement in the months ahead. Sharing learning between areas will also be a central feature of the programme as implementation progresses.

## Box 8: Resource implications

We anticipate that the impact of the above changes and wider changes arising from new models of care will be broadly cost neutral:

- Plans to enable 30% of face-to-face outpatient appointments to be replaced by more appropriate forms of care should enable around 4% of resources to be released to cover additional costs or increases in other elements of demand as a result of new eligibility criteria or other measures in this report.<sup>72</sup>
- Longer-term contracts to enable investment, a more differentiated approach between specialist transport, non-specialist transport and reimbursement, scope for more dynamism in non-specialist transport markets and better use of co-ordination to improve utilisation should improve productivity. In turn, this should free up resources for a more personalised approach and improvements in quality.

---

<sup>72</sup> We estimate 45% of NEPTS journeys are for outpatient appointments. The national outpatient transformation programme aims for a 30% reduction in face-to-face attendances by the end of 2022/23. This reduction in attendances could, if split evenly across all patient categories, lead to a 10-15% reduction in NEPTS journeys; however, we know this is unlikely to lead to the same reduction in resource use and costs. Older or more unwell patients who typically use NEPTS may not be able to transition to video appointments. Providers may also have fixed resources which are difficult to redirect to other types of journey such as transport for dialysis patients. Finally, some areas may have less rapid progress on outpatient transformation. Therefore, taking a conservative view, we estimate that at least 4% of resources should be released for any upward pressure on other forms of transport as a consequence of the review. We would hope that the resources released could be considerably higher, providing further scope for service improvement. Testing with local areas, including reviewing individual eligibility requests from hundreds of patients, indicated that the total impact of the package of measures including updated eligibility criteria, should be affordable within the current resource envelope particularly when wider factors such as outpatient transformation are considered.

- The cost of purchasing and leasing zero-emission vehicles will fall over the next decade, with battery powered electric vehicles expected to reach cost parity with internal combustion engine vehicles by 2030 or earlier.<sup>73</sup>

The delivery of these measures assumes that patient transport services are no longer significantly impacted by the COVID-19 pandemic. If infection prevention and control measures are still in place from April 2022, it is possible that the timetable for the delivery of some actions may need to be reassessed.

This is a strategic framework for system improvement and has national components where these are required. However, **in line with the NHS operating system, it seeks to pass down responsibilities to regions, ICSs and localities to reflect their particular circumstances and objectives.**

From April 2022, overall responsibility for non-emergency transport will transfer to ICS bodies, subject to legislation.

The Review heard a variety of views on how ICSs should manage their new responsibilities. These partly reflect the variety of commissioning and delivery models which currently characterise different parts of the country. For example, in London service design and management is largely arranged by healthcare trusts, whereas in the North West CCGs currently commission services across the region through a single lead CCG and team. There are pros and cons of different approaches. The work of the national improvement implementation team and greater transparency should aid the sharing of better practice in planning, commissioning and managing services.

All ICSs should ensure the development of services is in line with local patient needs, the delivery of integrated care, the duty to reduce health inequalities and the new national framework. Due consideration should also be made to any workforce implications that the framework could introduce locally, with service planning closely aligned to workforce planning to ensure that the right people with the right skills are available.

---

<sup>73</sup> Analysis by the Committee on Climate Change suggests price parity will be achieved by 2030, whereas Bloomberg New Energy Finance predicts it will be between 2025-2027.

While some commissioning arrangements will vary according to local needs, geography and market characteristics, we expect all to include the following elements:

- i. Each ICS body should have a lead officer with responsibility for oversight of non-emergency patient transport. It will be for the ICS body to determine the appropriate management level for that lead. ICS bodies should have a responsible officer / lead even in those areas where some responsibilities are pooled with other ICSs in a region or delegated to healthcare providers.
- ii. In line with the aims of ICSs, healthcare providers should be closely involved in the planning, commissioning and management of services to ensure that transport forms part of wider pathway improvements including discharge, outpatient transformation and renal services. This may include ensuring patient transport coordinators are embedded in discharge lounges.
- iii. Oversight and budgets should integrate NEPTS delivery, reimbursement, the Healthcare Travel Costs Scheme (HTCS) and wider transport facilitation. Given the benefits of system-wide co-ordination, we would not expect healthcare providers to hold ad hoc separate budgets and contracts for elements of NEPTS provision, although budgets may be delegated in a coordinated way.
- iv. Each ICS body should consider how to effectively coordinate with other system-level and regional partners including:
  - a. Urgent and emergency transport providers, to maximise utilisation of specialist vehicles and consider resilience arrangements where appropriate.
  - b. Local authorities, to explore scope for combined co-ordination for local non-specialist transport arrangements.
  - c. Other neighbouring ICSs, including to better manage journeys of patients who cross ICS boundaries, and any other aspects of common interest where economies of scale may be useful to consider.

To support the above, NHS England and NHS Improvement will establish a small implementation team to work closely with regions, ICSs, the sector and patients to deliver these actions. This will include an implementation advisory group comprising

senior representatives of all stakeholders, building on the work of the Review's Expert Advisory Group.

We will measure our success through the quality of patient satisfaction and safety, level of service co-ordination, service use, carbon emissions reduction and value for money.

## 6. Next steps

The Review aims to start a process of learning and improvement. To ensure that the recommendations of this review are put into action, there is a need for visible leadership and support at a local, regional and national level. A small non-emergency patient transport review implementation team will support the national delivery, aided by the Greener NHS Transport team, and advised by leaders of ICS, charities and patient groups and transport providers.

Among the specific milestones set out, the team will commission an evaluation of the strategy implementation and wider measures to support continuous improvement, the sharing of learning and engagement with stakeholders. Table 4 over the page sets out high-level milestones for implementing key actions:

**Table 4: Timeline for implementing key actions**

		Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	24/25 onward
<b>Updated national guidance on eligibility for NEPTS</b>									
i.	Consultation on eligibility criteria								
	Publication of new eligibility criteria								
	Phasing in new criteria								
<b>More accessible transport advice and support for patients more widely</b>									
ii.	Local approaches to HTCS improvement								
	Regulatory change on HTCS								
	Support local innovation and the growth of community transport / volunteers								
<b>Greater transparency on activity and performance</b>									
iii.	Development of recommended local dataset and model KPIs								
	Development of national minimum dataset								
	First data collection								
<b>A clear path to net zero patient transport</b>									
iv.	Zero Emission NEPTS								
<b>Better procurement and contract management</b>									
v.	Publish discussion paper on best practice procurement principles								
	Development of model service specifications & further guidance								
	Development of core standards for NEPTS								
<b>Cross-cutting actions</b>	Evaluation strategy								
	National advisory forum and dissemination of best practice								
<b>Wider contributory measures</b>	Reduction in carbon emissions								
	Free car parking for frequent attenders and other patient groups								
	Reductions in face to face outpatient appointments								
	Development of community diagnostics services								



Contact us:

**NHS England and NHS Improvement**

Skipton House  
80 London Road  
London  
SE1 6LH

This publication can be made available in a number of other formats on request.