Recommendations for the provision of a patient centred renal transport service
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• Detailed Supporting Information CD Rom

Located at the back of this document, the above CD ROM contains detailed information files in support of this report. More specifically, it contains a professionally designed PDF document (RTALS_DetailedSupportInfo.pdf) that is a primary information source with an interactive contents list and active links to the other files located on the CD ROM.
Foreword

Effective transport as a means to access healthcare is a key issue highlighted in a number of significant national policy documents. The increasingly important role of commissioners in securing effective patient centred transport in partnership with transport service providers is a central theme throughout. The provision of high quality, patient centred transport services, which are also cost effective, is the key challenge facing commissioners as they work towards meeting national targets in this area.

It is known that the provision of streamlined renal transport services presents significant difficulties. This is not just a local concern but is also highlighted at a national level and across a number of patient groups who rely upon Patient Transport Services (PTS). The Department of Health wanted to address these concerns and established two national action learning sets to explore the issues in renal transport as part of implementing the National Service Framework for Renal Services. These sets were in Cheshire and Merseyside and County Durham and Tees Valley.

This report of the Cheshire and Merseyside Renal Transport Action Learning Set summarises the work that has been undertaken to highlight the issues facing all renal patients but with a particular emphasis on haemodialysis patients. The Learning Set was established to learn from other areas where transport either works well or is facing significant pressure and to propose key recommendations to be considered both locally and nationally. It is however recognised that within these national recommendations, there is a need for local flexibility and it is expected that each area would need to develop their own local response within a nationally consistent framework.

This report identifies transport specific issues but also aims to raise wider awareness regarding the care of renal patients. The Learning Set has been given the opportunity and national support to systematically highlight the key issues and difficulties patients are facing and to help shape future policy in this area. The Learning Set’s recommendations are consistent with general national policy for PTS and could be used to support national benchmarking and audits in this area.

We hope that this report accurately captures the issues facing all those involved in providing or receiving renal transport and takes full account of national policy drivers. Finally, we hope that it inspires creative and innovative solutions developed in partnership to tackle this fundamentally important service area in order that we can become truly patient centred and make a real and practical difference to patients through a modernised transport service.

Cheshire and Merseyside
Renal Transport Action Learning Set
Overview

Haemodialysis patients dialyse 3 times a week for up to 4-5 hours each time, often over decades of care. This is a life saving but aggressive and tiring treatment and effective transport for these patients is an absolute pivotal part of their care.

Renal transport should aim to provide support to patients with as little disruption to their daily lives as possible. Transport is not simply about vehicles. A clear knowledge and understanding of the nature of renal care is fundamental if an understanding of how transport impacts upon the lives of patients and their carers is to be gained. In order to begin to understand how a patient feels when their transport is delayed, a useful comparison is to consider how someone might feel waiting for a taxi to the airport to go on holiday. If the taxi is late, this person may become anxious that they might miss their flight but on ringing up to find out the reason for the delay or the predicted time of arrival, are told that no one knows why or when it will actually arrive but to sit waiting. After half an hour of looking out of the window to see if the taxi is coming, this person would be highly agitated and anxious. Imagine the increased anxiety then if the journey is not a ‘one off’ for a holiday but a thrice weekly visit to hospital for a life saving but exhausting treatment, particularly as they know delays are likely to happen again on the return journey home.

A common theme throughout this work has been that patients should be supported in order to ‘dialyse to live and not live to dialyse’ and that the stress resulting from delayed or inappropriate transport is both unnecessary and preventable.

The number of renal patients requiring dialysis, and therefore transport, is projected to significantly increase each year for at least the next decade. It is therefore imperative that renal service and transport providers work together to prepare to meet these patients’ needs.

The recommendations made by the Learning Set have taken into account, and are fully consistent, with national policy and good practice guidance for the provision of PTS. They will help shape both local transport arrangements within Cheshire and Merseyside and will also share good practice across the wider NHS. Further detailed supporting information outlining the work undertaken by the Learning Set and giving examples of service specifications and good practice is available.
Cheshire and Merseyside Renal Transport Action Learning Set

The Cheshire and Merseyside Renal Transport Action Learning Set was established for one year in January 2005 with support from the Department of Health to address transport issues facing renal patients but with particular emphasis on regular haemodialysis patients. It had representation from commissioners, transport providers, renal service providers and patient advocacy.

The Learning Set met on a monthly basis and used a variety of methods to identify current practice and issues of concern which included holding two stakeholder events (A Listening Event and a Sharing Event), undertaking individual patient interviews, a survey of all ambulance trusts in England, a meeting with local ambulance trusts and meetings with representatives from other areas including visits to Bolton, Belfast, West Midlands and Greater Manchester. The purpose of these was to seek out examples of good practice where transport is working well and to identify the factors which promote a successful transport system. The work of the Learning Set supplemented previous audit work undertaken in Cheshire and Merseyside in order to provide an evidence base for the Learning Set’s recommendations. The Learning Set members also met up with representatives from the County Durham and Tees Valley Transport Learning Set as a ‘Buddy Set’. These joint discussions confirmed that the findings of both Sets were complementary and that the recommendations were consistent.
National policy drivers

There are a number of national policy documents and good practice guidelines regarding the provision of PTS and many of these specifically refer to the challenges of providing renal transport.


• The need to move from a finance driven to a quality driven service.
• The need to increase patient focus and flexibility of service provision.
• The need to pursue opportunities for co-operation with other agencies and authorities.
• The need to raise the status of PTS across the health community.
• The need to create the ability to meet rising expectations of user groups.

This was supported by the Audit Commission’s Report – Improving Non Emergency Patient Transport Services (2001) which forms a key reference document focussing specifically on PTS for patients and quotes a renal nurse:

‘renal patients hate their transport more than their treatment’

The Social Exclusion Unit also highlighted the importance of developing effective transport systems to facilitate equitable access to healthcare. The Unit’s report, ‘Making the Connections: Final Report on Transport and Social Exclusion’ (2003) highlights:

‘31 per cent of people without a car have difficulties travelling to their local hospital…
Over 1.4 million people say they have missed, turned down or chosen not to seek medical help … because of transport problems’

The report also states:

‘Too often, accessibility has been seen as a problem for transport planners to solve rather than one that concerns and can be influenced by other organisations for example by locating, designing and delivering services so that they are easily and conveniently available’

This is an important issue as improvements in renal transport must go hand in hand with expansion of local satellite dialysis provision. This will aim to reduce the travelling time that patients experience and will also aim to ensure a high quality of transport service is available for those who most need it.

‘Making the Connections’ summarised key recommendations regarding access to healthcare and these included providing additional guidance to Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and Local Authorities (LAs) on the role of PCTs in commissioning transport and having accessibility as a key factor within the Performance Framework of the NHS.
The NHS Purchasing and Supplies Agency (PASA) produced a procurement guide for the **Provision of Non Emergency Patient Transport Services and Non Patient Transport Services (2003)** which stated:

‘You may wish to consider exploring the options of a dedicated (renal) service...because the need is entirely predictable, the necessary resource allocation is much easier to quantify. In the case of renal patients, the attendance will perhaps be three times per week for years if not for life. Given the frequency of the attendance and the degree of debilitation associated with the condition it is vital that these patient groups receive a totally reliable service with knowledgeable staff. A dedicated service will foster closer relationships between driver and patients which will not only allow for a greater degree of personal care at this point of the episode but which will also enhance the patient experience’.

The **National Service Framework (NSF) for Renal Services: Part One Dialysis and Transplantation (2004)** outlined key standards and markers of good practice for renal care. It highlighted the importance of good transport for all renal patients but particularly haemodialysis patients many of whom are reliant on transport to get them to and from their weekly dialysis sessions.

The Renal NSF states:

‘Haemodialysis patients are disproportionately dependent on hospital transport services and the time and costs associated with hospital transport are major areas of concern internationally.

‘Adequate transport is so important to people on haemodialysis that it plays a vital role in the formation of patient views and attitudes towards dialysis. Good transport systems can improve patient attendance and shorter travel times can improve patient co-operation if the dialysis treatment frequency needs to be increased. Efficient transport facilities reduce interruption of patients’ social life and may therefore improve their quality of life. The development of satellite units and an increased availability of home haemodialysis can be convenient for the patient and also minimise transport costs’ (Renal NSF Part 1: points 86-87).

The Modernisation Agency’s Good Practice Guidelines in the report **Driving Change** (2004) clearly sets out the agenda facing commissioners of PTS services and provides examples of good practice and commissioning models. It states;

‘In the context of ‘National Standards, Local Action’, PCTs have the opportunity to take the lead in ensuring the provision of integrated emergency care and non emergency patient transport that is more responsive to the full range of current needs and preparing for major policy shifts, especially the full implementation of patient choice’.
Why is transport so important to renal patients?

A hospital haemodialysis patient will usually dialyse 3 times a week and dialysis normally lasts between 4-5 hours each time. This can be over many years and this treatment regime can be exhausting. After dialysis, a patient can feel tired and unwell and they may also have other medical conditions such as diabetes or hypertension which can exacerbate this meaning that patients cannot generally drive themselves, leaving them completely reliant on others to take them to and from their dialysis sessions. Some patients may have to dialyse a distance away from where they live and it is therefore very important that they can be picked up from their homes and taken quickly to their dialysis unit. Treatment for haemodialysis patients is provided mostly over 6 days every week (Monday – Saturday) including all bank holidays and into the late evening. As a consequence transport, as an integral part of renal care, should also be provided seamlessly to cover these times.

The difficulties experienced by some renal patients with their transport can cause significant distress and as a result, patients have been known to consider ceasing dialysis treatment. Research undertaken by Dr Paul Roderick et al.7 highlighted that if a patient lives more than 37 minutes away from a dialysis unit, they are less likely to be referred for dialysis, indicated by a 10% reduction in patient acceptance rate. This means that difficulties with transport have a real and measurable clinical impact.

The Cheshire and Merseyside Renal Strategy Group’s Strategic Framework recommended a standard of 30 minutes for a single journey time to and from the patient’s dialysis unit which is consistent with national guidance including the Renal Association’s standards for haemodialysis,8 but it is known that many patients take considerably longer than this due to a number of factors including the need to pick up several other patients on the way. Patients living in rural communities or who, due to their clinical needs, have to travel to a renal centre are also likely to take longer.

Dialysis patients receive care week after week often over many decades and this makes their transport needs very different to most other patient groups. Routine outpatient appointments do not last as long nor are they as frequent or tiring as regular dialysis sessions. **Transport for a renal patient is as fundamental a part of their care as the clinical service they receive.**

Work undertaken with providers across the country has highlighted that not every patient wants or needs an ambulance to take them to their dialysis unit and if there was better information and reimbursement available, many patients would actually prefer to make their own arrangements rather than rely upon hospital transport. This would enable the hospital transport service to focus on patients most in need. It should however be noted that even if a patient is not assessed as requiring hospital transport, they do still need access to support and information in arranging alternative forms of transport, receive appropriate reimbursement and also be regularly assessed as their needs may suddenly change and consequently they may then become eligible.

The number of patients who will require dialysis is estimated to almost double over the next 10 years and the main growth will be in older people with additional co-morbidities. They may well be less mobile and require more assistance in accessing their dialysis care. Whilst many renal patients at present either have a carer to drive them or are fairly mobile and do not require ambulance transportation, the dependency of patients will change over the coming years and it is therefore imperative that hospital transport is fully available for those patients who cannot travel by any other means.
The case for change

The Learning Set wanted to hear from as many people as possible regarding their views and experiences of renal transport. Case studies were gathered from around the country and this process proved invaluable in identifying areas where significant improvements could be made. Some of the many examples obtained include:

- Patients being left behind at their dialysis unit because their dialysis slot had overrun and the transport provider's shift was finishing.
- After hours service reverting to emergency ambulances who are then diverted to emergency calls leaving the patient waiting, sometimes for hours, at their dialysis unit before someone can take them home. In some cases, patients were admitted into inpatient beds simply because they could not be taken home.
- An elderly patient being dropped off by taxi at their home but not being taken to their door and subsequently falling on their garden path and being left in the cold and dark until a relative discovered them.
- A patient being physically attacked by security personnel over car parking issues.
- Elderly patients being dropped off for their dialysis session 2 hours early to fit in with transport shifts.
- A significant number of wasted journeys through lack of communication between patients, the renal unit and the transport providers.
- Patients being abusive to other patients or to the driver or using the ambulance journey for running errands such as buying a newspaper or bringing shopping home.
- Transport providers being unable to communicate with the patient in their own language and failing to ensure they were safely home.
- Patients having to sit next to the driver's dog as it could not apparently be left at home.

In many areas, volunteer driver schemes and use of contract taxis works well and patients express a high degree of satisfaction with their drivers who often may provide a more personal and reliable service but this can be very variable. Often, little training, if any, is given to these drivers to act in an emergency situation and they may not have a full appreciation of how the patient may feel after dialysis. It has been known for taxis not to turn up when particular social events such as football matches and races are being held due to the possibility of more lucrative fares and volunteers may not receive appropriate reimbursement for their services. In terms of establishing formal, explicit contracts with performance monitoring for these services, there are mixed views as to whether this would be appropriate or how it would be enforced.

The work of the Learning Set identified that there is considerable inconsistency in the approach to renal transport across the country. A survey of all ambulance trusts in England showed that of the 20 trusts who replied, 60% stated that they did not operate any eligibility criteria but their commissioners or local renal service provider did, the majority did not have renal specific contracts and no ambulance trust declared charging for transport despite anecdotal evidence to the contrary.

The work of the Learning Set has highlighted the case for change in renal transport and it is clear that no change is not an option.
Current transport provision and commissioning arrangements

The current arrangements for providing renal transport are often convoluted and have diffuse accountability. The renal unit staff are the main point of contact for the patient and carer but have little formal authority to address difficulties with transport and, indeed, may not be included within the negotiation of the hospital transport contract.

In the majority of areas, the funding for all PTS is given or ‘commissioned’ by individual PCTs to individual hospitals. Renal transport requirements are usually embedded within these general PTS contracts and may often not be clearly specified or described.

Within the hospital, the negotiation of the PTS contract with the ambulance provider will usually be undertaken through the general contracting or facilities departments, based upon historic contracts rather than a robust analysis of patient need. For the majority of PTS requirements such as outpatient journeys, this may well be appropriate but for renal transport requirements which are quite different, this often does not reflect the changing needs of the patient or the service.

The PTS provider may also be responsible for negotiating contracts with local taxi firms or volunteer drivers as part of the range of transport provision and again, renal service providers are not usually involved in these discussions. In addition, these contracts frequently do not include clear expectations on the taxi firms and volunteer drivers, making it difficult to address concerns or complaints.

Figure 1 illustrates the current typical model for transport commissioning and clearly demonstrates the large number of organisations involved with the PTS service. In one SHA area, there were 35 Service Level Agreements (SLAs) for PTS where only 1 had a renal specific element and the remaining 34 SLAs had included only a small element of renal transport making it virtually impossible to monitor performance or take action on concerns.

Figure 1: Current process for commissioning PTS services
In many areas, there is presently a disconnection between the commissioning of renal transport through PTS and the commissioning of renal services resulting in diffuse responsibility and a lack of clarity regarding the standards to be met. PTS is currently embedded within the tariff for acute activity but this is not felt to be the right model for renal services.

Figure 2 illustrates this disconnected commissioning and how often the negotiation of PTS contracts within hospitals will be undertaken without direct involvement of the renal service department. Whilst renal service providers can discuss concerns with the PTS and other transport providers, they have very little direct influence over the outcome.

In some areas such as Greater Manchester, a single commissioning lead for PTS has been established along a similar model as the single commissioning lead for emergency ambulance services which is much more widespread across the country. This lead commissioner acts on behalf of other PCTs in their area to negotiate the PTS contract. This has been found to significantly improve the coordination of transport commissioning and there is a much clearer route for resolution of the difficulties outlined. In some areas, renal services have already been separated out and renal service providers, commissioners and transport providers meet up regularly to review performance and discuss service planning issues.

In a number of areas however, transport providers are not routinely included in strategic planning around renal services and therefore new dialysis units have opened with transport being considered at the final stages when there is little scope for understanding and meeting the service needs. Transport should therefore be considered as an integral part of a renal dialysis service and should be included within service planning on an ongoing basis.
Commissioning a patient led transport service

Renal transport has generally been a provider and largely finance led service rather than being a patient / commissioner led service. This needs to be addressed by developing clear and robust renal transport contracts with identified funding, detailed service specifications with standards and performance monitoring requirements and a much stronger integration of renal transport and renal service commissioning.

Seeking patients’ views through annual surveys, reviewing complaints (both formal and informal) and holding stakeholder events enables transport providers to ascertain what is important to patients and carers and to see how well their services match against these expectations. Work undertaken through the Learning Set and previous local audit work across Cheshire and Merseyside has highlighted that patients would like the service to address the following:

1. The need to have a patient centred transport service which is flexible and reliable and which aims to reduce the stress for both patients and carers, enabling them to have minimal disruption to their lives. The transport providers should have well rehearsed back up plans should difficulties arise.

2. It should be consistent and with good continuity even when changes happen such as hospital inpatient episodes or patient holidays.

3. Renal transport could be better coordinated and should be separated out from general hospital transport contracts. It should have clear specifications and standards with a process for assessing performance against these.

4. The importance of communication both in terms of written information for patients and carers to understand the service and the benefits to which they are entitled but also on the day, should there be delays in the transport, being able to keep all people from the patient through to the driver and renal unit staff informed.

5. Vehicles should be clean, safe, well equipped and appropriate for the patients’ needs. Some patients require ambulance transport whilst others may be suitable for taxis or other forms of transport. Patients should therefore be regularly assessed for their transport needs based upon their clinical condition and mobility and should be offered options regarding their transport requirements.
6. Some transport providers may not be so familiar with the needs of renal patients and therefore additional support, information and training should be provided.

7. The journey time should be kept to a minimum, possibly by grouping patients into geographical areas for the same dialysis shift, reducing the number of patients picked up on each journey and by staggering dialysis start times. The majority of patients should be able to access their dialysis unit within 30 minutes travel time, recognising that patients who live in more rural areas, those who choose to dialyse further away from home or those that require more specialist care at a renal centre, may need to travel for a little longer.

8. Everyone involved in the transport service and the patient/carer have responsibilities and there should be greater clarity about the expectations on each individual.

9. Some patients have carers who would like to provide transport and they should receive appropriate financial support to enable them to continue to provide this service. As a part of this, all renal units should have dedicated parking so that patients and carers can easily park free of charge and this should be borne in mind in any future dialysis unit developments. This is in accordance with NHS Estates Guidance Health Building Note 53.

10. The use of new technology to aid communication, such as vehicle tracking and route finding should be used in order that vehicles and transport staff are utilised most efficiently, as is the case in emergency transport.
Listening and learning – emergent key themes

The Learning Set identified a number of key themes throughout its work which if addressed would make a significant impact upon renal transport:

- **Commissioning** – effective commissioning is fundamental if renal transport is to be patient centred. Commissioners need to have the authority, funding and information to challenge and makes changes if necessary and not to have renal transport embedded within overall contracts with little flexibility.

- **Communication** – communication difficulties often lie at the root of transport problems and solutions to these must be found. This may include developing a single point of contact for organising transport and the use of technology to assist in keeping all aware of any difficulties.

- **Consistency** – there is a need for a consistent approach to be adopted both locally and nationally. This does not mean uniformity as one size does not fit all but it will ensure a fair and equitable service meeting at least minimum national standards is available to all patients.

- **Choice** – patient choice is very much as the centre of the transport recommendations. Transport providers should offer a range of options which enable patients to make a choice, taking into account their clinical needs including whether they make their own arrangements. There may be a number of different transport providers offering different elements of the overall service.

- **Criteria** – clear criteria to determine the nature of transport services provided are very important. Not all patients require or want an ambulance and many patients could travel with a carer if this was appropriately reimbursed. Assessment of need against eligibility criteria is an ongoing process and should be undertaken by the clinical team.

- **Coordination** – there needs to be overall coordination of renal transport and a single point of contact for arranging this. The lines of accountability need to be clearer and more simplified.

The two major issues of concern highlighted throughout the Learning Set’s work were:

- **Eligibility criteria for transport**
- **Charging for transport**
Eligibility criteria for transport

With very few exceptions, patients undergoing regular haemodialysis treatment will not be fit enough to drive themselves to and from their treatment sessions. This does not mean however that hospital transport should automatically be provided without an assessment of the patient's clinical need. Where a patient is assessed as requiring assistance in travelling for mobility or medical reasons, transport should be provided, the type of vehicle and staff being determined by the clinical condition of the patient. This assessment should be undertaken sensitively and respectfully by the clinical team in partnership with the transport providers. It should be regularly reviewed (at least every 3-6 months) to take account of changing needs and ensure that transport remains appropriate for the patient. Concerns have been expressed regarding the subjectivity of this assessment for eligibility and it appears to be one of the main areas of national inconsistency. It is therefore proposed that further work be undertaken to develop national eligibility scoring criteria which reduce this local interpretation of need.

Where a patient is assessed as not requiring assistance in travelling, a ‘menu’ of transport options should be shared with the patient which could include:

- Volunteer driver services.
- Dial and Ride or other similar local community or public transport services.
- Local bus/tram/train service information.
- Local taxi companies.
- Use of own vehicle driven by carer/family member.
- Use of other vehicles (friends or family).

It is recognised that patients in more rural areas have particular needs for PTS transport as the alternative options available to them may be very limited and this must be taken into account in assessing a patient’s need for transport.
Charging for transport

No patient who is assessed as requiring assistance with transport for mobility or medical needs should be charged. This requirement is clearly set out within the NHS Guidance issued in 1991, which states that non-emergency PTS to and from hospital is provided free of charge when patients have a medical need.

There will need to be some flexibility in responding to patients from rural communities where alternative transport options are more limited.

All renal patients and carers should have access to free car parking at their dialysis unit.

All patients should be made fully aware of their rights to a range of benefits under the Hospital Travel Costs Scheme and this should be explained to them as many find this a complicated and confusing system. Some patients may require assistance in obtaining and completing the necessary documentation.

It is anticipated that the majority of renal patients will be eligible for hospital transport due to their medical and mobility needs. There is the widespread view that all renal patients, whether eligible for hospital transport or not, endure a rigorous and demanding schedule of life-saving treatment over decades of care and that it is considered only fair and appropriate that any reasonable travel costs incurred by the patient or carer should be reimbursed. This may include fuel costs and car parking charges where appropriate. This reimbursement should reflect the actual costs incurred but should be reasonable and should not be above the cost of the equivalent journey by ambulance.

By facilitating choice, reimbursing costs and providing free and accessible car parking at the dialysis unit, many patients would choose to make their own arrangements, particularly parents with children requiring renal care. The recently published renal NSF document ‘Working for children and young people’ (DOH 2006) states:

“Effective hospital transport services, dedicated parking spaces for dialysis units and the availability of help with fares for families on low incomes can all play a part in reducing the stress of travel, thereby increasing patient attendance and improving quality of life for the whole family”.

This is a considerably more cost-effective way of providing this service than large and increasing numbers of patients who are reliant upon hospital transport and it provides the patient with more control over their arrival and departure times.
A Renal Transport Charter

Throughout the work of the Learning Set, it became clear that everyone involved in renal transport has their own part to play in making this a more effective service.

An example Transport Charter is outlined below which identifies the responsibilities on each group in the provision of a patient centred renal transport service and highlights expectations for the service. It is recognised that there will always be exceptional circumstances which will impact upon these but these charter statements represent the guiding principles which should be developed and adopted locally to enhance respect and understanding throughout the service. It can also be used as a tool for engaging with a wide range of stakeholders in monitoring the quality improvement in transport services.

1.0 Patient and Carer Responsibility

- To be ready at the allocated time for pick up from home.
- To make the transport provider aware if they have made alternative travel arrangements.
- To be polite and non offensive to the drivers and fellow passengers.
- To use the transport provided appropriately and not to abuse its use.
- To provide feedback to Trusts and transport providers when transport is working well and also when it has not met expectations.

2.0 Trust / Unit Responsibility

- To ensure the appropriate transport is booked according to the mobility of each patient.
- To review regularly the mobility of patients and their need for transport to be provided.
- To ensure that the patient’s dignity is maintained at all times.
- To liaise with transport providers and patients/carers and notify of any delays in the patient’s treatment.
- To provide free, secure parking for patients/carers.
- To ensure adequate provision is made for transport when planning expansion of dialysis services.
- To provide transport providers with all the relevant patient information e.g. if the patient is blind.
- To provide transport providers with information and training regarding the needs of renal patients.
3.0 Transport Provider Responsibility

- To meet quality standards outlined within the contract specification.
- To provide safe, clean, smoke free vehicles appropriate to patients' requirements.
- To ensure that the patient's dignity is maintained at all times.
- To ensure all patients are properly secured into the vehicle with seat belts or wheelchair restraints as appropriate.
- To provide all appropriate stakeholders with accurate information.
- To ensure timely pick up for patients.
- To have an awareness of the needs of the renal patient and act accordingly.
- To advise the dialysis unit of any concerns regarding the patient.
- To provide a flexible, patient focused service.

4.0 Commissioner Responsibility

- To meet regularly with transport and renal service providers.
- To regularly seek the views of all stakeholders, particularly patients and carers regarding the transport service they receive.
- To set out clear quality standards in a service specification.
- To monitor performance against quality standards, service specification and contract activity.
- To take action if transport providers consistently fail to meet service requirements.

How should the charter be used?

The charter is intended to be developed locally and to make explicit the responsibilities and expectations with regard to transport provision as practice guidance. Each renal patient should be given a copy of the charter and it should be available in all local renal units. Transport providers, renal service providers and commissioners will also all receive a copy of the charter and it will form part of the transport contract service level agreement and will be used in all performance monitoring.

What are the benefits of having a charter?

A charter makes clear what patients can expect from the transport service and their role within this. It sets out guiding principles and values that will become integral to the provision and commissioning of this service.

If all stakeholders have a better understanding of the issues facing each other and the role they play, this should lead to a greater appreciation of the need to meet the charter requirements.
Future commissioning of renal transport services

It is clear from this work that the commissioning of renal transport needs to be strengthened, integrated and simplified. The current commissioning of renal transport has too many organisations involved resulting in fragmentation of the service, lack of clarity regarding service requirements and significant potential for communication difficulties.

It is therefore proposed that in place of all PCTs within a given area managing renal transport through general PTS contracts, the renal specific elements are separated out and managed through a single commissioning lead, ideally linked with the lead commissioning arrangements for specialised renal services as illustrated in Figure 3.

It is fundamental that the funding for renal transport services does not become embedded within the tariff for renal services as this will remove the flexibility for commissioners to change transport arrangements in response to patient need.

Implementation of the commissioning requirements would be through a single coordinator who would act as the main point of contact for patients, carers, renal service and transport providers. The coordination point for renal transport has been highlighted through the work of the Learning Set and follows the national models of good practice for PTS. For this to function effectively, it would be crucial for the coordinator to have clear lines of reporting and accountability and to have the authority to act should service providers fail to comply with the service requirements as set out in their contract. This function would support renal service providers in resolving operational difficulties, would support patients and carers in arranging transport and informing them of their rights to benefits. They would act as the implementer of the commissioning intentions and would be the focus of transport provider contacts. The detail of this function could be determined locally within the proposed model.

Figure 3: Proposed Commissioning Model for Renal Transport
## Recommendations for renal transport services

The Learning Set summarised its findings into a set of recommendations to be considered both locally and nationally.

<table>
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<tr>
<th>Key Issue</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>National consistency</td>
<td>• The recommendations contained within the work of the 2 Renal Transport Learning Sets are adopted as a national framework for renal transport, recognising the need for local flexibility in their implementation.</td>
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| Strengthened commissioning                | • A single lead commissioner for renal transport should be identified within each area, linked to the lead commissioner for renal services.  
• Renal transport should be removed from general PTS contracts with identified funding.  
• Renal transport should be kept separate from any national tariffs for renal services in order to maximise flexibility in commissioning this service.  
• A renal specific service specification with quality standards and eligibility criteria for transport should be produced using measures of success for performance management.  
• Value for money and service responsiveness in transport contracts should be sought. This may include increasing the range of service providers offering renal transport including the independent sector.  
• The views of patients and carers should be listened to through stakeholder events, review of formal and informal complaints and focus groups. New ways of capturing non formalised complaints including use of comments cards and suggestions boards should be considered. |
| Eligibility criteria and transport needs assessment | • All renal patients should be assessed at least every 3-6 months or more frequently if clinical needs change and their transport needs reviewed for their medical and mobility requirements and appropriate transport options offered.  
• A national eligibility criteria scoring approach should be developed to ensure a consistent approach. |
| Improved communication                    | • A single point of contact for renal transport such as a transport coordinator / bureau function should be established locally.  
• Use of information technology and equipment to improve communication should be explored. |
| Partnership working                       | • Links between renal service planning and transport provision should be strengthened by having named representatives on local renal strategy groups or by establishing a transport subgroup of local renal strategy groups.  
• Transport providers should be involved in strategic planning discussions for renal services on an ongoing basis not just at the final stage. |
| Patient and carer charges and benefits    | • No renal patient who is assessed as being eligible for transport should be charged for transport.  
• All renal dialysis patients and carers should have access to free, secure and accessible car parking and all new units should be designed with these requirements in mind in accordance with HBN53.  
• Patients should be given clear and up to date information regarding their benefit rights under the Hospital Travel Costs Scheme and support in completing their applications.  
• A local policy on the reimbursement of travel costs for patients/carers should be developed to address the recommendation that all reasonable carer expenses incurred as a result of driving the patient should be reimbursed. |
| Promoting choice                          | • A menu of transport options which can be tailored to individual patient needs should be developed. This would need to be sufficiently flexible to respond to changing needs. |
| Making roles and responsibilities explicit | • A local Transport Charter setting out responsibilities and expectations should be developed and shared widely. |
| Enhancing non ambulance transport provision | • All transport providers should be offered training and information regarding renal services and should be regularly assessed.  
• All transport providers should provide evidence that their vehicle meets safety and all legal requirements and they can demonstrate an awareness of patient needs.  
• All reasonable volunteer driver expenses incurred as a result of driving the patient should be fully reimbursed.  
• All transport providers should be able to communicate with the renal service provider and / or patient regarding any difficulties. |
| Emergency patient transfers               | • Each local hospital should have an agreed protocol with their renal centre regarding transfer of renal patients.  
• Each local hospital should have an agreed protocol with their ambulance trust regarding transfer of renal patients. |
Proposed minimum quality standards

The Learning Set reviewed a number of different areas of good practice in proposing these 4 minimum quality standards. These would form part of the contract monitoring schedule and would need to be audited by both the transport provider and the receiving renal unit. Once these minimum standards have been met locally, these could be revised within local contracts to set more challenging standards.

<table>
<thead>
<tr>
<th>No.</th>
<th>Proposed Standard</th>
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<tbody>
<tr>
<td>1.</td>
<td>• A minimum of 75% of patients should access their renal dialysis unit within 30 minutes travelling time of their home.</td>
</tr>
<tr>
<td>2.</td>
<td>• A minimum of 85% of patients should arrive on the dialysis unit no earlier than 30 minutes before their dialysis start time.</td>
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<tr>
<td>3.</td>
<td>• A minimum of 75% of patients should leave the hospital no later than 30 minutes after their dialysis completion time.</td>
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<tr>
<td>4.</td>
<td>• 100% of patients/carers should receive free car parking at the dialysis unit.</td>
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How will success be measured?

It is proposed that the following measures are incorporated into renal transport and renal service contracts and are measured through systematic audit on an ongoing basis. Many of these areas will be specified within service specifications and will be subject to formal inspections (e.g. state of vehicles) therefore some of the measures outlined here are more concerned with the perception and view of patients and carers. It is also recognised that there are different sources of information to monitor these measures – some may be renal unit based whilst others will be through the renal transport provider and submission of this information will form a requirement of the contract. Where possible, existing data collection and information sources should be used.

It is proposed that these are evaluated through a variety of means including:

• Patient / carer satisfaction surveys.
• Monthly analysis of contract activity information (both transport and service providers).
• Routine inspection.
<table>
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<tr>
<th>Key Factor</th>
<th>Proposed areas for monitoring</th>
<th>Suggested method of Audit</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| Journey times                     | • Percentage of single journey times to dialysis unit over 30 minutes.  
• Percentage of single journey times to patient's home over 30 minutes.  
• Time difference between stated and actual pick up time.  
• Number of patients picked up per single journey.  
• Percentage of patients arriving on the dialysis unit no earlier than 30 minutes before their planned dialysis start time.  
• Percentage of patients leaving the hospital within 30 minutes of their actual dialysis finishing time.  
• Postcode of patients experiencing delays.  | Contract monitoring data from transport provider and renal service audit data.             | Monthly    |
| Journey distance                  | • Postcode of patient’s home address and dialysis unit address to determine distance travelled and whether they accessed most local dialysis unit.                                                                 | Renal service audit data.                                                               | Quarterly  |
| Eligibility criteria and mode of transport | • Existence of eligibility criteria and a process of regular assessment of need in place for transport.  
• Percentage of patients travelling by different modes of transport (ambulance/taxi/volunteer driver/carer/community transport etc).  
• Percentage of patients using their preferred mode of transport.  | Transport provider data.                                                               | Monthly    |
| State of vehicles                 | • Vehicles are clean, roadworthy and have appropriate equipment.  
• Vehicles have communication systems installed.                                                                                                                        | Patient survey.                                                                        | Annual     |
| Patient / Carer reimbursement     | • Patients are kept fully informed of the Hospital Travel Costs Scheme.  
• Carers receive reimbursement for travelling expenses.                                                                                                              | Patient survey.                                                                        | Annual     |
| Car parking arrangements          | • There are dedicated car park spaces in close proximity to the renal unit and these are free to renal patients and carers.                                                                                                     | Patient survey.                                                                        | Annual     |
| Aborted journeys                  | • Number of aborted journeys.  
• Postcode of these aborted journeys.  
• Reason for the aborted journeys.                                                                                                                                           | Transport provider contract data.                                                      | Monthly    |
| Communication and coordination    | • The transport provider has access to satellite navigation or other technology.  
• There a single Renal Transport Coordinator / bureau.  
• The transport provider rings the dialysis unit and the patient to notify of delay.                                                                                     | Transport provider contract information.                                               | Annual     |
| Complaints                        | • Number of formal written complaints received.  
• Identification of the main reasons for these complaints.  
• Identification of the process for dealing with these complaints and how the outcome is used to improve organisational effectiveness.  
• Recording and actioning of verbal and informal complaints.                                                                                                                | Transport and Renal Service provider information.                                      | Monthly    |
| Patient satisfaction              | • Renal patient satisfaction surveys are regularly carried out and evidence of actions taken to address findings. Service improvements as a result of actions to be identified.                                                 | Patient survey.                                                                        | Annual     |
| Dialysis Unit Operational Function| • Shift systems run by the dialysis unit.  
• Staggered shift times.  
• Identification of the shift where most delays occur.                                                                                                                 | Renal Service data.                                                                   | Quarterly  |
| Contract management               | • A separate contract is in place for renal transport.  
• A detailed specification to support the contract is in place.  
• Funding for renal transport is clearly identified with an analysis of each transport mode.  
• Regular contract monitoring meetings are held with the transport provider.  
• Identification of the lead negotiator of taxi contracts and volunteer drivers.                                                                                     | Commissioning information.                                                            | Annual     |
| Training requirements             | • Taxi and volunteer drivers receive formal training to act in an emergency and demonstrate an awareness of patient needs.  
• Taxi and volunteer driver service is regularly reviewed and monitored.                                                                                                  | Transport provider information.                                                       | Annual     |
**Timescales for action**

The Renal NSF set out a 10 year framework of actions to be implemented by 2014 but with renal transport, there are more immediate timescales for action.

The development of a tariff for renal and ambulance services by 2008/09 using reference costs requires clarity regarding the renal transport issues in order to inform the national discussions. This means that these transport issues need to be resolved by summer 2007 at the latest in order to inform this process and set the foundations for a patient centred transport system.

**Members of the Cheshire and Merseyside Renal Transport Action Learning Set**

The Cheshire and Merseyside Renal Transport Action Learning Set met on a monthly basis between January 2005 and March 2006 and comprised of the membership as shown.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Simon Banks</td>
<td>Specialised Commissioning Manager &amp; Lead Commissioner for Ambulance Services</td>
<td>Cheshire and Merseyside Specialised Services Commissioning Team</td>
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<tr>
<td>Dennis Crane MBE</td>
<td>North Regional Advocacy Officer</td>
<td>National Kidney Federation</td>
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<td>Andy Hickson</td>
<td>Assistant Director of Operations (PTS)</td>
<td>Mersey Regional Ambulance NHS Trust</td>
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<tr>
<td>Sarah Reynolds</td>
<td>Commissioning and Service Improvement Manager</td>
<td>Southport and Formby PCT</td>
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<tr>
<td>Jenny Scott</td>
<td>Head of Specialised Commissioning &amp; Lead Commissioner for Renal Services</td>
<td>Cheshire and Merseyside Specialised Services Commissioning Team</td>
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<tr>
<td>(Facilitator)</td>
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<tr>
<td>Marcella Sherry</td>
<td>Renal and Transplant Directorate Manager</td>
<td>Royal Liverpool and Broadgreen University Hospitals NHS Trust</td>
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References


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- Our Transport ‘Buddy Set’ colleagues in County Durham and Tees Valley.
- Our colleagues in the renal community and transport providers across the country but particularly Frankie O’Kane, Gary Miskelly and Peter Wilson in Belfast, Sister Barbara Murray in Bolton, Graham Roberts and Chris Evans in Greater Manchester and Bev Matthews in the West Midlands Renal Network.
- Mandy Chivers who inspired us to become action learners.
- Most of all, our patients, carers and local NHS colleagues and Renal Strategy Group who have given us so much advice and information which has helped to shape these final recommendations. Particular thanks go to our Learning Set members who moved on to new roles during the lifetime of the Learning Set including Michelle Fleming, Sarah Hodson, Judith White and Shahid Ali.

If you would like to find out more about renal transport issues, you can contact:

Jenny Scott, Head of Specialised Commissioning on 01244 650426 or e mail jenny.scott@cwpct.nhs.uk and Dennis Crane, North Region Advocacy Officer, National Kidney Federation on 0161 740 5550 or e mail dennis.crane2@virgin.net.

Copies of the text of this booklet can be made available in large print and arrangements will be made for an audiotape on request. Translation into other languages can also be arranged.

This document and supporting information is also available at www.cmssct.nhs.uk (n.b. NHS access only).
Detailed Supporting Information
CD Rom

CONTENTS – DOCUMENT FILES

• Recommendations for the provision of a patient centred renal transport service – Detailed Supporting Information PDF (RTALS_DetailedSupportInfo.pdf)

The above PDF file is a professionally designed document containing additional detailed information in support of this printed report. When using the CD ROM, this PDF is a primary information source which has an interactive contents list and active links to the other files located on the CD ROM.

• Section 13:
  DH_HospTravelCostsScheme.pdf
  NHS_HelpwithHealthCosts.pdf
  NHS_TaxCredits_HC11(1C).pdf

• Section 14:
  RTALS_AccessToRenalServices.pdf

• Section 15:
  RTALS_ListeningEventNews.pdf

• Section 16:
  Example Service Specifications and Contracts
  16.1: Greater Manchester
  GM_Haemodialysis_InfoSheet.pdf
  GMRHS_NonEmergencyTrans.pdf
  16.2: Cheshire and Merseyside
  MRAS_SLA_RenalPatientTrans.pdf
  16.3: West Midlands
  WestMids_Specification.pdf
  16.4: Belfast
  RSS_SpecialCond_RenalTrans.pdf
  BCH_Service_Agreement_Trans.pdf
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Simply double click the CD icon on your desktop and then double click on the file you want open.

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