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P288 -Our experiences working with the implementation of new eligibility criteria for patient transport for renal patients. Practical reflections on what we have learnt and suggestions for colleagues.

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Introduction

Transport for renal patients is one of the most significant influences on overall patient experience. For patients who use transport it can come to be the single factor that dominates their response to their treatment. The author and colleagues have seen transport experiences both significantly impact patient compliance with treatment and also influence the choices patients make about dialysis.

Against this background the lead CCG for our area implemented new eligibility criteria for transport in 2018. This abstract will explore the issues this raised for us and offer suggestions for how others respond to a similar challenge.

The implementation of new criteria

Prior to July 2018, patient transport (PTS) was offered to all patients with medical need. This was established by considering whether patients had specific mobility impairment OR had side effects from their condition which precluded public or private transport.

In July 2018 the lead CCG for the area implemented the use of an algorithm, operated by the PTS provider, to establish eligibility. This was largely based on mobility as a decision had been made that mobility was an adequate reflection of ‘medical need’.

What happened

All patients currently on haemodialysis were required to telephone personally to go through the questions. When first initiated, this resulted in a significant number of patients ‘failing’ the questions and being told their transport would be removed. Through a combination of reassessment, involving intervention from clinical and social work staff and patient complaints, all but one patient were eventually deemed eligible. This patient featured in local media and was supported by KidneyCareUK until transport was awarded.

Originally the lead CCG mandated that all patients must contact the provider 3 monthly for reassessment of need. On representations from the renal service this was revised and medical need is now reassessed by the PTS provider in discussion with renal staff. To date no patient has improved in their condition sufficiently to mean transport is withdrawn.

A number of recently transplanted patients were also refused transport. On discussions with the lead CCG it was agreed transport should be automatically provided for the first 6 weeks post transplant and longer if clinically required.

Currently there is one dialysis patient who does not meet the criteria and consequently has moved their dialysis shift and is taking two buses each way, covering 16 miles, to reach dialysis. Representations will continue to be made by the service on behalf of this patient.

Next steps

The service will continue to push for the inclusion of frequency of appointment as part of the criteria. This will qualify all dialysis patients.

Recommendations for others

- Involve the full MDT including nephrologists and social workers.
- Engage in frequent and early reviews to assess the impact of any changes.
- Reassure patients, signposting to additional support and advocacy services.
- Do not assume system partners will understand the impact of renal failure. Be explicit and vocal about the potential impact that restrictions in transport availability has on patient health and aspirations.