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| Non-Emergency Patient Transport Review |
| Discussion paper May 2023 |
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# Foreword



The Victorian Government is delivering on its election commitment to conduct a review of non-emergency patient transport (NEPT) in Victoria - making sure Victorians are connected to the right care.

NEPT is a critical feature of Victoria’s health system and ensures that people who need monitoring on their way to or from hospital can be transported safely. Last year alone, over 385,000 transports were completed by Ambulance Victoria and private providers.

NEPT services also play a pivotal role in freeing up Ambulance Victoria’s emergency crews to respond to the most time critical patients, reducing hospital discharge delays and freeing up access for other patients to receive care.

Because of this, it’s imperative that NEPT services are operating as effectively as possible and so I’m pleased to be leading this review of the NEPT system – to see what’s working and how we can do better.

The review is wide-ranging. As well as considering future procurement arrangements, it is assessing broader ways to improve timeliness of services, make full use of the skilled workforce, tackle fragmentation, support financial sustainability, and explore ways to better coordinate the system so Victorians are connected with the right transport for their specific needs.

The review is guided by conversations with the sector and those who interact with it, including NEPT staff and providers, Ambulance Victoria, health services, industrial partners, peak bodies, and most importantly Victorians who use NEPT services.

This discussion paper marks the beginning of these conversations. It aims to provide an overview of how NEPT services are delivered in Victoria, the current challenges facing the sector, their underlying causes, and emerging potential options for reform.

The paper contains many discussion questions and I’m looking forward to your thoughts on them, which can be provided through a public submission.

Over the coming months I’ll be speaking with the entire patient transport sector – and those who engage with it – about the challenges discussed here and the opportunities for improvement to ensure Victorians have access to high-quality, well-resourced NEPT services both now and into the future.



**Steve McGhie MP**NEPT Review Lead

# **Introduction**

## Context

* On 18 November 2022, the Victorian Government made an election commitment to review the existing procurement arrangements for non-emergency patient transport (NEPT).
* In addition to assessing whether outsourcing NEPT services is the most effective model, this review is also identifying opportunities to get more value out of the system and improve experiences for both patients and staff.
* It is incredibly important for Victorians to have ready access to health care. But this can only occur if safe, effective, and appropriate transport options are available to patients. NEPT services play a crucial role in the system and need to be operating as effectively as possible. That’s why this review is considering what’s working and how we can do better.

## Terms of Reference

* The terms of reference for the review outline the review’s scope, including procurement arrangements, timeliness of services, workforce skills, tackling fragmentation, financial sustainability and connecting Victorians to the right transport.[[1]](#footnote-2)
* This focus allows for a comprehensive look at NEPT services to ensure they meet the needs of the Victorian community both now and into the future.
* The review is being led by Member for Melton Steve McGhie, with a final report to be presented to the government for consideration by the end of 2023.

## Purpose of this discussion paper

* This discussion paper aims to support constructive suggestions on practical solutions for improving NEPT services.
* The following chapters provide an overview of current sector challenges, their underlying causes, and emerging options for reform.
* Public submissions are invited on ideas for responding to the challenges outlined and opportunities for improvement. Key questions are included throughout the paper to guide contributions.
* Submissions responding to the discussion paper, alongside wider consultation and commissioned technical expertise, will inform the final review report and recommendations.

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| Submissions should be returned to: neptreview@health.vic.gov.au Submissions will be received until close of business 14 July 2023. Please advise at the time of submission whether you give permission to the Department of Health to publish your submission, or quote from it in the final report and/or any products related to the review. Further updates on the review will be provided through the review website: https://www.health.vic.gov.au/patient-care/non-emergency-patient-transport-review.  |

# How are NEPT services set up in Victoria?

## NEPT services play a critical role in Victoria’s health system

* NEPT services are for patients who require transport to and from public health services.
* To access NEPT, a patient must be assessed by an authorised health professional[[2]](#footnote-3) prior to transport as meeting key eligibility criteria. These include:
	+ the patient does not need a time critical ambulance response
	+ there is a need for clinical monitoring during transport, and/or reduced mobility which requires stretcher transport
	+ the patient’s condition is not likely to deteriorate or become time critical during transport.[[3]](#footnote-4)
* A wide range of Victorians use NEPT services (see Box 1).
* NEPT transfers occur either in between hospitals, or between hospitals and the community.
* Most transfers are by road, with a small number undertaken by air services.[[4]](#footnote-5)

Box 1: Who uses NEPT?

|  |
| --- |
| People from all over Victoria rely on safe, timely and affordable NEPT services to access public health services. Common user examples include:* A frail patient living in a remote area who needs to travel to a metropolitan specialist health service,but cannot make the long road journey and must be transported and cared for by a NEPT flight nurse.
* A patient who has recently suffered a heart attack, is now stable, and is being transferred from their local treating hospital to another hospital for specialist care.
* A frail aged care facility resident who needs to attend a specialist appointment at their local hospital, but can only be transported laying down and so cannot safely travel seated in a taxi or facility van.
* A patient who has had a severe infection and needs to be expertly managed with complex infusions while travelling from a regional hospital to a specialist hospital in Melbourne.
 |

### There are two kinds of NEPT transfers

* There are two kinds of NEPT transfers: planned and unplanned.
* Planned NEPT typically involves transporting people between hospitals, from hospitals home to the community, or from the community to specialist appointments.[[5]](#footnote-6)
	+ Planned NEPT is booked in advance and the patients have already been assessed in-person by an authorised health professional.
* Unplanned NEPT typically originates in Triple Zero calls from the community.
	+ Triple Zero calls are assessed and triaged by an Emergency Services Telecommunications Authority (ESTA) call taker.
	+ Calls that are identified through the ESTA call-taking process as lower acuity and less urgent are directed to Ambulance Victoria (AV)’s secondary triage service, which provides further assessment over the phone. This process determines whether a NEPT response is appropriate for the patient.
	+ AV then directs NEPT crews to travel to the patient to provide further assessment and transport to hospital.
* Planned transfers make up the majority of NEPT in Victoria –approximately 81% of all NEPT services in Victoria 2021-22.
* Both planned and unplanned transfers range in their clinical complexity, from low to high acuity.
	+ The lack of prior in-person assessment for unplanned transfers can increase their risk, with NEPT crews typically the first health professionals to physically assess a patient in-person.
	+ Planned transfers have had prior in-person assessment by an authorised clinician before the NEPT crew arrives. However, the clinical complexity of these transfers can still be high.

### Both kinds of NEPT play a critical role

* NEPT is a significant industry in Victoria. Every year, health services and AV spend about $155 million on NEPT services. This funds more than 385,000 transports a year and employs about 2,000 frontline workers.
* NEPT plays a vital role in getting Victorians to public health services. Without NEPT services:
	+ patients who need help with transport to access healthcare, but not a lights-and-sirens response, could face long waits
	+ patients who need non-urgent clinical assistance during travel would have to be transported either by ambulance (at a higher cost) or a non-clinical transport service (which does not provide the required level of care)[[6]](#footnote-7)
	+ some patients may have to make their own arrangements, with the potential for prohibitive costs for patients living in rural Victoria or requiring regular transports.
* NEPT also plays an important role in supporting health system capacity, enabling other patients to access care faster, including:
	+ the diversion of non-time-critical Triple Zero requests to NEPT supports AV to focus on emergency cases that require time critical medical attention
	+ in public emergencies, NEPT services can also take on the lowest acuity ambulance callouts in situations where demand exceeds ambulance capacity, such as during the 21 November 2016 thunderstorm asthma event when Triple Zero calls suddenly increased by 73%[[7]](#footnote-8)
	+ NEPT transfers from hospitals play a vital role by freeing up beds and reducing discharge delays, improving system-wide efficiency, and increasing the operational capacity and timeliness of health services.

## Over 2,000 skilled workers deliver NEPT in Victoria

* Victoria’s NEPT workforce plays an essential role in the patient journey; supporting patients to move safely and comfortably between health services and the community.
* The size of the frontline workforce is significant with around 2000 staff.
	+ This includes around 1,300 patient transport officers, 500 ambulance attendants, 100 registered nurses, 60 critical care nurses and 30 enrolled nurses (see Table 1).[[8]](#footnote-9)
	+ This is a significant workforce. By way of comparison, AV currently employs around 5,000 on-road clinical staff.[[9]](#footnote-10)

### Most NEPT workers are employed by private providers rather than AV

* The workforce is predominantly employed by the private providers who deliver the bulk of NEPT services in Victoria.[[10]](#footnote-11) Just over 5% of NEPT workers (around 110) are directly employed by AV across NEPT and clinic transport services.[[11]](#footnote-12)
* There is no standardised Enterprise Bargaining Agreement for the private NEPT workforce. The majority of workers are employed on casual contracts, with varying pay and conditions, as discussed in Section 3.5.
* Many members of the workforce are employed by AV at varying points in their careers.
	+ The NEPT sector can be a pathway into other roles, particularly for people early in their careers, as well as a pathway for people seeking a lower-intensity workload at later stages of their careers.[[12]](#footnote-13)
	+ Some AV employees looking for additional work may also do shifts with private NEPT providers.
	+ Paramedics work in the NEPT sector as Patient Transport Officers or Ambulance Transport Attendants (see below). This is because there is no defined role nor scope of practice for paramedics within the NEPT sector at present.

### Regulations set the skill requirements for NEPT workers

* To ensure the safety of both the NEPT workforce and patients using NEPT services, regulations require the workforce to have appropriate skills, competencies, and knowledge, including ongoing training and professional development.
	+ This includes a core set of capabilities such as patient assessment and the principles of trauma care, as well as the safe provision of certain controlled medicines.[[13]](#footnote-14)
* Beyond these core capabilities, the level of qualifications and required skillset for NEPT workers vary depending on the classification of the role outlined in Victoria’s NEPT Clinical Practice Protocols (Table 1).
* The minimum staffing requirements for NEPT differ by patient acuity and transport platform and are determined by the regulations and Clinical Practice Protocols(see Table 2).

Table 1: NEPT workforce minimum qualifications[[14]](#footnote-15)

| Classification | Minimum professional qualification |
| --- | --- |
| Patient transport officer (PTO) | Certificate III in Non-Emergency Patient Transport\* |
| (Endorsed) Enrolled nurse division 2 (EN/EEN) | Diploma of Nursing\* |
| Ambulance transport attendant (ATA) | Diploma of Emergency Health Care\* |
| Registered nurse division 1 (RN1) | Bachelor of Nursing\* |
| Registered Nurse Critical Care (CCRN) | Bachelor of Nursing and post-graduate certificate and experience in a critical care area |

 \* or equivalent

Table 2: NEPT crew-mix requirements[[15]](#footnote-16)

|  |  |
| --- | --- |
| **Acuity** | **Minimum crew member required to travel in patient compartment** |
| Low | PTO |
| Medium | ATA (unplanned ambulance or interfacility transport)EN/EEN (interfacility transport or if trained and endorsed unplanned ambulance)RN1 (interfacility transport or if trained and endorsed unplanned ambulance) |
| High | CCRN |

## The Department of Health’s NEPT role focusses on regulation

* The Department of Health (the department) is the steward of Victoria’s health system and has a range of levers at its disposal to manage and shape the system (as discussed further in Section 4.4 below).
* As this section shows, the department does not directly commission NEPT services and the main levers it employs in relation to NEPT are regulatory.

### The department’s main role in relation to NEPT services is a regulatory one

* The department’s regulatory powers are based on three instruments: the Non-Emergency Patient Transport and First Aid Services Act 2003 (the Act), the Non-Emergency Patient Transport Regulations 2016 (the Regulations) and the Non-Emergency Patient Transport Clinical Practice Protocols 2023 edition.
* With these powers, the department determines who can provide NEPT services by granting NEPT licences,[[16]](#footnote-17) and the regulatory framework prescribes standards for NEPT services. This includes the minimum and maximum patient acuity that can be serviced with NEPT, how patients are transported and vehicles staffed, accreditation and quality assurance, vehicles and equipment, and infection control.
* The department is also responsible for holding providers to account for complying with regulations. It does this using a combination of education, assessments, and statutory enforcement powers. Compliance is monitored proactively through snap inspections, standardised assessments during licence renewal periods, and reactively in response to complaints. Administrative action (notice to comply, notice to produce and licence suspensions) is the primary mechanism to enforce compliance.[[17]](#footnote-18)

### The department does not directly purchase NEPT services

* The department does not directly purchase NEPT services. Instead, it funds AV and public health services, who may then use the funding to contract NEPT services.
	+ AV receives funding from DH for both emergency (ambulance and air ambulance) and non-emergency (NEPT and other) services.
	+ Health services receive activity-based funding from DH, which is to cover all of the costs associated with patient care including the transport of patients.
* This funding ensures that eligible patients with concession cards in Victoria do not incur any charge when using clinically necessary NEPT services. Patients who are not eligible for concession cards and are not covered by other arrangements such as the Membership Subscription Scheme or WorkSafe are charged in line with the Ambulance Services Payment Guidelines.[[18]](#footnote-19)

### HealthShare Victoria facilitates contracting, but not bulk-purchasing, of NEPT

* As noted above, the purchasing and performance management of contracted NEPT services is decentralised to health services and AV.
* However, a centralised contracting approach is run for health services by HealthShare Victoria (HSV).
	+ HSV is responsible for procurement and contracting negotiations on behalf of all health services, to maximise their collective purchasing power and achieve greater value in the procurement of a range of goods, services and equipment that health services need, including NEPT.
* HSV has established a state-wide contract with a panel of four NEPT providers.
	+ Health services are free to choose which provider(s) on the panel they wish to work with. They may engage a provider using the HSV contract, or develop a local service agreement with the provider that builds on the state-wide contract and adds, for example, additional local key performance indicators, and/or local volume-based discounts if the health service’s NEPT use reaches a given volume.
	+ AV is not required to use the state-wide panel and manages its own procurement and contracting of NEPT services with providers directly.
* HSV contracts offer concessional pricing, but stops short of bulk-purchasing
	+ The HSV contract saves health services from having to work through their own procurement processes for NEPT, reducing duplication of administrative costs.
	+ The contract also achieves concessional pricing, but not the volume-based discounts that can be achieved under a bulk-purchasing agreement.
	+ Bulk-purchasing agreements have been negotiated by HSV for some services it procures for health services (such as waste management, where successful bidders are awarded geographic zones in which they are the primary provider).
	+ Under the HSV NEPT contract, health services retain the choice of NEPT provider and the ability to switch between them, so that volumes for providers are not guaranteed.

## There are multiple purchasing arrangements for NEPT

* AV and health services are both responsible for securing NEPT services for patients. 70% of NEPT services sit under AV (which delivers some of these directly but secures most through outsourcing arrangements). Health services are responsible for the remaining 30% of all NEPT services.[[19]](#footnote-20)
* The split of responsibilities between AV and health services has been criticised as overly complex.
* AV purchases all unplanned NEPT (which it then either subcontracts or delivers internally), while health services and AV share responsibility for purchasing planned NEPT.
* The split of responsibilities for planned NEPT varies depending on the type of patient and the direction of the transfer (see Table 3 below).
	+ AV is the default purchaser of planned NEPT for patients with concession entitlements in most instances, and the purchaser of inter-hospital transfers by exception (e.g. for admitted patients under TAC/VWA schemes).[[20]](#footnote-21)
	+ Public health services are the purchasers of inter-hospital transfers in other instances.
* In some cases purchasing and payment responsibilities are also split. For example, AV is responsible for purchasing NEPT for patients covered by the Transport Accident Commission (TAC), and then seeks reimbursement from this scheme.

Table 3 Purchasing Responsibility[[21]](#footnote-22)

|  |  |  |
| --- | --- | --- |
| Transfer type | Patient type | Purchasing responsibility |
| AV | Health service |
| Unplanned (000-derived) | All | ü |  |
| Planned – Transfers to/from community | General patient  |  | ü |
| Concession patient\* attending a public admitted facility or emergency department | ü |  |
| Concession patient attending HIP/specialist clinic |  | ü |
| TAC, DVA or VWA | ü |  |
| Planned – Inter-hospital transfer | General, Concession or DVA patient attending a public admitted facility or emergency department |  | ü |
| Concession patient attending a non-admitted facility | ü |  |
| TAC or VWA | ü |  |

\* Concession classification includes Pensioner, Health Care Card holders and compulsory mental health patients

## There are many providers of NEPT in Victoria

* In total, 13 private providers are licenced to deliver NEPT services in Victoria, with a fleet of approximately 450 stretcher vehicles.[[22]](#footnote-23)
* Of the 13 private providers, six provide NEPT services for AV and public health services. AV contracts all six, while public health services (under the HSV panel arrangements) contract four providers.[[23]](#footnote-24)
* AV deliver some NEPT services in-house (approximately 30% of the total volume they are responsible for) as do some health services.[[24]](#footnote-25)
* AV has a default role as the provider of last resort in the absence of the private market.[[25]](#footnote-26) As the private sector is generally very ‘thin’ in rural and remote areas, the AV fleet is often used in this context. If AV NEPT cannot service these cases, they spill to AV’s emergency resources.
* In metropolitan areas, AV contracts private providers to meet a significant portion of its NEPT requirements. There is no clinical role delineation between AV NEPT services and contracted NEPT services; with workload allocated based on the availability of resources.

## There are multiple booking and dispatching arrangements

* As Section 2.4 above described, AV and health services share responsibility for contracting planned NEPT services.
* This means that most health services must book transfers for patients through two different mechanisms, depending on who is purchasing the transfer.
	+ For transfers purchased by health services, transfers are booked directly with private providers, which have their own call-taking and dispatching arrangements. This includes the Hospital Based Vehicle program, operating across eight major metropolitan health services, which uses separate booking systems depending on which contractor is allocated to that service.
	+ When AV is responsible for triaging NEPT, health services book the transfer through ESTA[[26]](#footnote-27) using either an online booking form[[27]](#footnote-28) or a ‘1300’ number for same-day bookings and patients with mental health related needs.
* Health services are required to book NEPT purchased by AV directly through AV using one of the above two channels, even if AV will ultimately contract the same NEPT provider that would be contracted by health services directly.

## NEPT is interlinked with other sectors of the Victorian health system

* There are critical interdependencies between NEPT services and other sectors of the Victorian healthcare system that must be considered when planning for potential changes to the NEPT sector.
* First, many NEPT providers deliver other essential healthcare services.
	+ These include delivery of NEPT for private hospitals, along with first aid services at community events,[[28]](#footnote-29) first aid and mental health training, and other functions such as COVID-19 testing services and drug and alcohol testing.
	+ In general, public NEPT is a core part of these providers’ businesses, and may generate revenue to cross-subsidise the other essential functions. This means that any shifts to the composition of the NEPT sector might impact the sustainability of business practices across these other services.
* Second, NEPT indirectly impacts other patient transport services in Victoria.
	+ These include emergency (ambulance) services and non-clinical transport (see Figure 1 below).
	+ Any potential instability in the NEPT sector has spill-over consequences for these services, which would need to absorb any unmet demand.

Figure 1: Summary of patient transport in Victoria



## NEPT in Victoria has changed a lot over time

* The NEPT sector underwent transformative change over the past three decades, initially moving from an integrated public service to an outsourced one with very limited regulatory or clinical governance overlay.
* In recent years the sector has changed with much stronger regulation and clinical governance of and within the sector, occurring in tandem with significant market consolidation.

### Regulation of the NEPT sector has strengthened

* **Before 1993**, NEPT was a public service delivered by the former Metropolitan Ambulance Services (MAS), which provided both emergency and non-emergency patient transport. There was criticism of this model, with MAS seen to prioritise emergency services over NEPT, causing delays in access to routine care.
* **In 1993**, the Victorian Government separated NEPT from emergency ambulance services and privatised the former.*[[29]](#footnote-30)* Initially, NEPT was managed solely by MAS through direct contractual arrangements.[[30]](#footnote-31) But as private volumes grew beyond MAS’ contracted services, this ‘second tier’ of NEPT became effectively unmanaged from a clinical governance perspective, with private NEPT providers simply regulated under the *Transport Act 1983* and licensed by the Taxi Directorate.
* **In 2003,** the*Non-Emergency Patient Transport Act 2003* was introduced. This legislation recognised the industry’s unique characteristics and mandated that all NEPT providers must hold a licence in Victoria.
* **In 2021**, amendments were made to the NEPT Regulations to strengthen the requirements for safety and quality of care. These regulations set minimum standards for NEPT to minimise risks to patients without imposing onerous costs on licence holders.[[31]](#footnote-32) The Department of Health assesses compliance standards and provides education.

### The private NEPT market has expanded, then consolidated again

* The composition of the private NEPT market has fluctuated significantly over time (see Figure 2 below).
* In 2012, there were 14 licensed providers, with half of them receiving contracted work from AV. Volumes were relatively concentrated, with one provider securing more than 40% of the tender market.[[32]](#footnote-33)
* Between 2012 and 2021 the number of licensed providers grew to 20, before a period of consolidation. In the last two years, the volume of providers reduced from 20 to 13, with five licenses cancelled or suspended due to non-operation or minimal operation.[[33]](#footnote-34)
* At present, the majority of NEPT services are delivered by six of the 13 registered providers.[[34]](#footnote-35)

Figure 2: Evolution of the private NEPT market in Victoria

### NEPT provider responsibilities have evolved over time

* There have also been significant changes in the responsibilities of NEPT providers. As noted above, the quality and safety standards NEPT providers must meet have strengthened significantly.
* NEPT provider responsibilities in relation to the delivery of public duties and support of major incidents have also shifted. The 2021 amendments to the *Non-Emergency Patient Transport Act 2003* removed the previous ‘standby’ provision for NEPT services.
	+ Under this provision, NEPT providers were accredited to provide staff and vehicles to attend public events and provide stand-by services to eventgoers experiencing unexpected illness or injury.
	+ However, it was possible for licence holders to subvert the intent of this provision by obtaining a NEPT licence with no plan to actually transport patients. This would give the provider access to approved scheduled medicines, which would be a competitive advantage over other first aid providers. This created a potential risk for event attendees as the previous regulations only covered the minimum requirements for patient transport, rather than first aid treatment with scheduled medicines[[35]](#footnote-36).
	+ The amendments created a separate set of regulations – the *Non-Emergency Patient Transport and First Aid Services (First Aid Services) Regulations 2021* - to set minimum standards for the event first aid and medical sector.
	+ These amendments and the licensing and regulation of the first aid sector replaced stand-by accreditation of NEPT licensees.
* NEPT providers have also come to play an important role in emergency responses under the State Emergency Management Plan.
	+ During emergencies or major incidents the State Health Commander or Ambulance Victoria Emergency Management Director may command non-emergency patient transport.
* As part of AV’s three tier escalation process,[[36]](#footnote-37) NEPT services may take on increased responsibilities.

## Victoria’s approach to NEPT is different to other jurisdictions’

* A mix of purchasing, delivery and regulatory approaches to NEPT are in place around Australia (see Table 4 below).
* Half of the states and territories in Australia deliver their NEPT services through a public entity.
	+ In South Australia, Queensland and the ACT the state ambulance services deliver NEPT.
	+ In NSW, NEPT has been recently separated from ambulance services and delivered by a statutory body with broader health supply chain delivery responsibilities.
* The rest of the states and territories (including Tasmania, Western Australia and the Northern Territory) contract NEPT services from private providers. However, Victoria is unique in terms of the size and competitiveness of its private NEPT sector. Outside of Victoria, jurisdictions either:
	+ contract with fewer providers (one in the case of the Northern Territory and three in Western Australia, in contrast to Victoria where AV and health services contract with up to six providers) or
	+ manage a much smaller NEPT market (low acuity services only in the case of Tasmania, in contrast to Victoria where NEPT providers deliver low, medium and high acuity services).
* Victoria is also the only state or territory to have standalone regulation that is specific to its NEPT sector. Other jurisdictions regulate their NEPT sectors under their wider health legislation and/or accompanying regulation and policies (see Appendix 2: Jurisdictional comparison of procurement arrangements).
* Not all jurisdictions use NEPT to support emergency Triple Zero calls.
	+ In Victoria and Queensland, following secondary triage, a NEPT service may be dispatched to patients not requiring an emergency response.
	+ In contrast, secondary triage services in South Australia do not make use of NEPT and redirect patients to other care pathways.

Table 4: Jurisdictional arrangements for NEPT delivery\*

|  | Vic | NSW | Qld | SA | WA | NT | Tas | ACT |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Delivery approach** |  |  |  |  |  |  |  |  |
| Primarily outsourced  | ü |  |  |  | ü | ü |  |  |
| Primarily insourced  |  | ü | ü | ü |  |  | ü | ü |
| **Role of ambulance services** |  |  |  |  |  |  |  |  |
| They mostly deliver it  |  |  | ü | ü |  | ü | ü | ü |
| They mostly subcontract it | ü |  |  |  |  |  |  |  |
| They are one of many subcontractors |  |  |  |  | ü |  |  |  |
| They are fully separate |  | ü |  |  |  |  |  |  |
| **Regulatory approach** |  |  |  |  |  |  |  |  |
| NEPT-specific regulations | ü |  |  |  |  |  |  |  |
| NEPT under health regulations |  | ü | ü | ü | ü | ü | ü | ü |
| **Service consolidation**  |  |  |  |  |  |  |  |  |
| Single provider  |  | ü | ü | ü |  | ü |  | ü |
| 2-3 providers |  |  |  |  | ü |  |  |  |
| 4+ providers | ü |  |  |  |  |  | ü |  |
| **Rural service provision** |  |  |  |  |  |  |  |  |
| Single provider responsible  |  | ü | ü | ü | ü | ü | ü | ü |
| Multiple providers  | ü |  |  |  |  |  | ü |  |

\*See *Appendix 2: Jurisdictional comparison of procurement arrangements* for further detail

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| **Consultation questions – *How are NEPT services set up in Victoria?**** Have the essential features of the Victorian NEPT sector been captured in this chapter?
* What additional features of the sector do you feel are important for the review to consider?
 |

# How is the sector currently performing?

## Quality and safety appear strong, with regulatory compliance high and adverse events rare

### Assessed compliance to new regulatory standards is high

* The vast majority of NEPT providers deliver a safe and high-quality service for patients in Victoria, with service standards improving, through regulatory reform and increased scrutiny, and maturity of the sector.
* The department monitors the regulatory compliance of NEPT proactively through ‘snap’ or no-notice NEPT inspections, workforce engagement, and responding to complaints or issues identified by complainants and during licence renewal processes.
* Over the last 12 months, the department has conducted 42 no-notice inspections of NEPT vehicles and equipment across Victoria.
	+ These inspections review compliance against regulatory standards for NEPT vehicles and assess whether vehicles are appropriately equipped and in working order.
	+ These inspections have identified high levels of compliance to regulatory standards across NEPT fleets.
* Additional inspections carried out as part of the licence renewal process include an assessment of back-of-house processes such as clinical governance, record keeping and other administrative activities. These inspections have also identified high levels of overall compliance across the sector.
	+ For example, the 2021 regulatory changes require provider investment in vehicles and equipment to meet minimum standards. The first transition period to expire was for the provision of lifting cushions which were required to be in all NEPT vehicles by 30 November 2022. Inspections have indicated full compliance with this standard across the sector, with work underway to meet the other standards before the respective transition periods expire.

### Patient safety processes are being strengthened

* Adverse patient safety events are incidents which result in harm or injury to a patient.
* These events occur in all modern health systems. Australian research suggests that around one in every 10 patients suffers a complication of care during their hospital stay, with half of those complications avoidable.[[37]](#footnote-38)
* Since 2016 the Victorian health system has enacted extensive reforms to ensure that such events are closely monitored to continuously improve patient safety and system performance.[[38]](#footnote-39)
* Since the 2021 regulatory reforms, this oversight has now also been strengthened in the NEPT sector.
	+ The most serious adverse events (sentinel events)[[39]](#footnote-40) are managed in line with Safer Care Victoria’s sentinel events process for the wider health system. This requires providers to report the event within 24 hours and conduct a detailed root cause analysis, open disclosure to patients and families, and review of internal policies and processes to learn from such incidents and further improve safety.
	+ Other adverse events[[40]](#footnote-41) must now be reported to the department through provider annual reports, and providers must have quality assurance plans in place detailing their approaches for management and handling of adverse events.
	+ Adverse events which occur following the dispatch of unplanned NEPT services by AV are continuing to be managed separately by AV in line with their internal clinical governance processes.
* Adverse events in NEPT services are relatively infrequent, in line with the comparatively low acuity of these services. In 2021-22:
	+ no sentinel events directly related to NEPT care or service delivery were reported[[41]](#footnote-42)
	+ 53 adverse safety events were reported by providers to DH,[[42]](#footnote-43) with around 25 relating to patient safety.[[43]](#footnote-44)

## Access is variable, due to gaps in supply and collection delays

### Timeliness of services is variable

* Health services report that the timeliness of NEPT services is highly variable.
* Delays to NEPT services adversely impact patients and their families. Patients remain waiting in hospital or transit lounges for longer than necessary, and in some cases miss essential appointments due to delayed pick-ups from the community.
* Delayed NEPT services also impede patient flow, by reducing health services ability to free up patient beds and admit new patients. A recent departmental bed audit survey found that waiting for interhospital transfers were common reasons for delayed discharge from acute and subacute wards.[[44]](#footnote-45)
* Health services report particular frustration in managing delays when there is limited ability to track expected NEPT pick-up times and scheduling changes. This has been reported as a particular challenge when services are booked through ESTA for AV-funded patients, as health services do not directly contract with the provider and receive limited updates on progress of the request.
* Delays may also be a particular challenge for patients being discharged to aged care facilities, where patients are often not accepted after 5pm. Patients may be faced with an extra night in hospital if not picked up in time to meet the cut-off time of the aged care facility.
* Health services can also contribute to delays in cases where patients are not ready for transport, or the receiving health service is not ready to receive a patient when the NEPT provider arrives.

### Supply gaps have caused spillbacks to emergency services

* Where NEPT providers are unable or unwilling to meet demand, there are spillbacks of both planned and unplanned NEPT demand to emergency services. Spillback pressures have increased in recent years as a result of the rapid growth in demand for NEPT services which has outpaced allocated resourcing and rostered shifts (explored further in Sections 4.2 and 4.3).
* Unplanned NEPT services directed to private NEPT providers but which spilled over to AV emergency crews increased from 2.63% of total NEPT services in 2020 to 2.74% in 2022.[[45]](#footnote-46)
	+ While less frequent, planned NEPT services also spill to emergency services. The proportion of these increased from 0.65% in 2020 to 0.96% of total NEPT services in 2022.[[46]](#footnote-47)
	+ For total NEPT services (planned and unplanned) that spilled to emergency crews in 2022, 87% of the spills occurred in rural areas. 71% of these rural spills were unplanned transfers, and were directed to NEPT following triage but then re-directed to emergency crews when no NEPT options were available. This indicates that spillbacks are largely happening due to market failure: a lack of private sector coverage in rural areas means that AV are forced to intervene. This may also be occurring due to a resourcing mismatch between acuity platforms, such as AV servicing rural areas with mostly single stretcher medium acuity where the service demand is for low acuity multiple load resources.
* Spillbacks are highly undesirable as they make paramedics unavailable for other emergency callouts. Their effect is felt most severely in rural areas where significantly longer journey times may prevent emergency crews from responding to other incidents for several hours. This significantly increases costs, and can result in patients who need ambulances waiting longer to be seen. It can be frustrating for the ambulance workforce to provide back-up NEPT, as their skills are not put to best use.

## Cost growth is putting pressure on providers and health services

* NEPT providers report facing increased operating costs, with flow on impacts reported by health services.
* According to provider reports,
	+ inflationary pressures are leading to increased provider costs in areas such as fuel and workforce wages
	+ operational pressures have been further exacerbated since by the COVID-19 pandemic, which has required providers to rapidly adapt to social distancing and broader infection prevention and control requirements, including stricter PPE, cleaning, and contamination requirements
	+ NEPT providers continue to experience workforce shortages, arising from furlough and increased workload and demand from AV.
* Following on from the 2021 regulatory changes, NEPT providers also report making significant capital investment to ensure compliance standards are met.
* Overall, NEPT providers report absorbing an increasing proportion of these operating costs, which is placing strain on the sector. Some health services report increasing pass-through of these costs.

## The environmental impact of the sector is significant

* Like many other parts of the health system, NEPT services are a contributor to Victoria’s climate emissions.
* There are more than 450 vehicles across private providers, each of which has travelled an average of 245,000 kms – the equivalent of 290 trips to the moon.
* AV has committed to achieve net zero carbon emissions by 2045. All AV sites have been powered by renewable energy since 2022, with a transition to hybrid and electric vehicles in progress.[[47]](#footnote-48)
* While a number of private providers have pledged to reach net zero emissions, targets and timelines across the sector are mixed and some providers have no publicly-committed emissions targets.

## Workforce pay and conditions vary, creating broader challenges

* Industrial partners report that the fragmented nature of NEPT services in Victoria results in varied pay and conditions across the sector, with these reportedly often poorer than for the AV NEPT workforce.
* The majority of the NEPT workforce (around 85%) are employed on casual contracts.[[48]](#footnote-49) Such contracts limit the workforce’s ability to access paid leave, paid sick leave[[49]](#footnote-50) and guaranteed hours of work.[[50]](#footnote-51)
	+ While casual workers may receive additional pay (or loadings) to compensate for the lack of these entitlements, the instability generated by these contracts has seen calls for NEPT providers to decrease the proportion of their workforce employed under casual arrangements[[51]](#footnote-52).
	+ Some providers are responding positively to this call for change and have committed to increase their permanently employed workforce, however this approach is not uniform across providers.[[52]](#footnote-53)
* NEPT workers also move between employers frequently, but there is limited portability of entitlements such as sick leave.[[53]](#footnote-54)
* Industrial partners have also highlighted that broader working conditions are often poorer.
	+ As one example, while both AV and ESTA have comprehensive mental health support programmes for their employees, similar programmes for NEPT workers in private providers are limited. This is despite exposure to many of the same risks as public sector emergency workers.[[54]](#footnote-55)
* NEPT workers employed by private providers have also expressed discontent at being ineligible for incentives such as the Hospital Surge Support Allowance paid to public sector healthcare workers (including AV employees).
* The disparities in pay and conditions have, in some instances, led to strike action by patient transport officers within some providers.[[55]](#footnote-56)
* These varying conditions may also contribute to ongoing challenges with workforce attrition in the private sector. Private providers report a significant and ongoing flow of staff moving from private providers to AV.

**Consultation questions – *How is the sector currently performing?***

* Do you agree with the summary of the key strengths and current challenges facing the NEPT sector that has been outlined in this discussion paper?
* Are the current quality and safety standards for NEPT services in Victoria appropriate for the sector, and appropriately enforced?
* Does this discussion paper fairly reflect the pressures on timeliness and costs of NEPT services?
* Have the sector’s environmental impacts and policies been fully captured?
* Have the issues regarding workforce pay and conditions been fairly reflected?

# What is causing these problems?

## Market fragmentation drives up costs and slows down transfers

* Challenges with costs and timeliness are partly due to recent pressures, like the COVID-19 pandemic and global inflation. They are also partly due to the inherent inefficiency of Victoria’s NEPT market design.
* The high volume of private providers in the market has created competitive pressure, keeping prices down. But it has also fragmented the market, creating duplication and diseconomies of scale that push costs up.
* This section describes three forms of fragmentation in the Victorian market: duplication of overheads for NEPT providers, inefficiencies in transport routes, and administrative complexity for AV and health services. It shows that some of these inefficiencies are inevitable, and others have arisen in response to the way the market is managed.

### There is duplication of operational overheads

* A major advantage of single-provider NEPT systems is their economies of scale in procurement and services. Common functions can be performed once, rather than many times over. This reduces the cost of functions like asset procurement and maintenance, workforce recruitment and training, booking and route planning systems, and administrative and managerial overheads.
* Victoria’s multi-provider system has the benefit of facilitating competition, but overhead costs are duplicated across every provider under current arrangements, reducing overall efficiency.
* This duplication is not inevitable, as there are ways of minimising duplication in a multi-provider system.[[56]](#footnote-57)
	+ In parts of the Victorian public health system there are multiple providers but consolidation of shared functions. For example:
	+ rural and regional health services are required to jointly procure information and communications technology services through five regional alliances based on a joint venture model[[57]](#footnote-58)
	+ HSV supports efficient procurement across the health sector (including AV), as described in Section 2.3. This saves each organisation from needing a full-size procurement team, and for some goods and services (such as medical consumables and waste management) there are also savings through bulk-purchasing.[[58]](#footnote-59)
	+ In some jurisdictions, organisations that are like HSV also provide expansive shared services, in addition to bulk procurement.
	+ For example, HealthShare NSW delivers all core accounting services, linen, uniforms and laundry, patient food, innovation prototyping, and emergency vehicle cleaning and restocking for the NSW Local Health Districts and other health agencies.
	+ In the private sector, organisations may also seek the support of specialist procurement organisations to achieve economies of scale for common good and services.
	+ Organisations such as Procurement Australia support multiple private organisations, including those in health and aged care to streamline procurement.[[59]](#footnote-60)
* More could likely be done to reduce provider overheads, with shared benefits across the system.

### There are inefficiencies in scheduling and route planning

* High and reliable patient volumes are critical for the efficiency of patient transport services. They:
	+ enable overheads to be spread across a larger revenue base (lowering the cost per trip)
	+ reduce the time that transport vehicles are empty or only half-full (incurring fuel and workforce costs while earning no or limited revenue) when they travel between collection / drop-off points.
* In Victoria, with six providers delivering NEPT for public health services and AV, individual provider volumes are inherently limited.
* Further, there is no coordination of volumes to maximise what economies of scale can be achieved.
	+ Victoria’s 75 health services can each choose their preferred NEPT provider from the four on the HSV panel, with no requirement to use the same provider that AV or other health services use in their area.
	+ AV does contract on a geographic basis, with providers awarded the right to be its ‘preferred’[[60]](#footnote-61) operator for unplanned NEPT in each of 17 zones, but with limited coordination of neighbouring zones so that there are often still multiple AV contractors in a given geographic corridor.
* This has resulted in a situation where there are multiple providers in almost every region of Victoria, and as many as four in some.[[61]](#footnote-62) In one region all health services use the same provider to deliver their planned NEPT, but AV still contracts a different provider to deliver its unplanned NEPT in this region.
* With no geographical coordination for these providers, the chance of vacant return trips and poor vehicle and crew utilisation increases (see Figure 3 below). This inefficiency is greatest in rural areas where one-way trips can average three hours.[[62]](#footnote-63)
* NEPT providers often rely on both AV and direct contracts from health services to achieve sustainable volumes. But both AV and some health services also provide their own NEPT services, which further dilutes volumes for NEPT providers (but is considered by AV and those health services to be unavoidable).
	+ This fragmentation and dilution of volumes undermines the efficiency of private providers, increasing the volume of return trips with empty vehicles. It also dilutes provider volumes in already thin rural markets, increasing costs to the point where providers either withdraw from markets altogether, or charge prohibitively high prices to cover costs. In either case service provision will typically default to AV as provider of last resort. In 2022, there were 13,200 transfers that were eligible to be delivered by NEPT providers but ‘spilled’ to AV, with 87% percent of these occurring in rural areas.
	+ In single-provider systems these challenges are minimised for obvious reasons, but they can be minimised in multi-provider systems too. For example, Western Australia allows metropolitan health services to select from a panel of four private providers to meet their low and medium acuity NEPT needs but requires all country health services to use a single provider.[[63]](#footnote-64)
* Limitations in booking systems mean that NEPT requests are not booked or allocated with route efficiency in mind.
	+ For example, when allocating a NEPT request to a private provider, AV has limited visibility of the provider’s existing bookings. This limits AV’s ability to allocate a job which would slot into existing trips and avoid the need for a return trip with a vacant vehicle.
	+ While the majority of NEPT services are planned (rather than unplanned), most trips are booked on the day transport is required rather than in advance. This puts further limits on providers’ ability to plan and efficiently allocate resources.

### Inefficiency in route scheduling exacerbates the environmental impact of NEPT

* As Section 3.4 above noted, the NEPT sector has a significant environmental impact.
* Inefficient use of NEPT resources exacerbates this, leading to additional and potentially unnecessary kilometres travelled due to empty return trips (see Figure 3: When transfers are not coordinated, and underloaded vehicles (i.e., vehicles that have a single patient when it is safe and appropriate to double-load).[[64]](#footnote-65)
* This increases the total emissions across the sector, with variable policies in place to limit these (for example through electric vehicles) or offset them.
* The inefficiency also has broader impacts on the sector, which is struggling to contain costs and maintain a timely supply of services amid surging demand and workforce shortages.

### There is administrative complexity and duplication in NEPT service purchasing

* The fragmentation of responsibilities for purchasing NEPT between health services and AV (as described in Section 2.4) creates administrative complexity and duplication at multiple levels.
	+ AV does not use HSV’s panel for NEPT procurement, instead running its own procurement and contract management processes with duplication of function and personnel.[[65]](#footnote-66)
	+ The requirement for most health services to request NEPT transfers through AV channels for some patients and directly from their provider for other patients (as described in Section 2.6) further duplicates costs, with the need for additional booking systems and training of staff to use them.
* This creates confusion for operational and clinical staff at health services, which increases administrative costs and has led to health services allocating scarce resources to resolve billing disputes arising from complex funding arrangements.

Figure 3: When transfers are not coordinated, services are less efficient



**Consultation questions – *Market fragmentation***

* What are the most appropriate options for addressing the existing challenges of complexity, duplication, and inefficiency associated with market fragmentation?
* What other examples can be drawn upon to guide best practice in this area?
* Which changes would have the biggest impact on the environmental sustainability of the sector, and create efficiencies enabling reinvestment?

## There is excess demand, not all of it appropriate

* Delays in NEPT services are partly attributable to excess demand.
* State-wide planned NEPT services provided or purchased by AV have grown an average of 6.9% per annum between 2015 and 2019.
	+ Low acuity NEPT services grew by an average of 7.7% per annum over the same period, largely underpinned by a 27.1% increase per annum in rural areas.[[66]](#footnote-67)
	+ As a comparison, total demand for Triple Zero grew at 4-5% per annum over the same period.[[67]](#footnote-68)
* Some of this demand may be inappropriate and could be met more appropriately through other means.
	+ Inappropriate demand for NEPT services occurs when patients are incorrectly assigned to NEPT, despite not meeting the criteria and thresholds for it.
	+ Inappropriate demand increases pressure on the system, meaning more patients who appropriately require NEPT services wait longer or miss out. Crews must choose between refusing to transport the patient (significantly delaying the patient’s onwards journey) or breaching NEPT regulations by providing a NEPT transport inappropriately (which delays access to NEPT for other patients, with flow on consequences for the system).
* NEPT services may also be dispatched to patients whose needs are subsequently found to be too acute for management by NEPT.
	+ In the most recent 12-month reporting period, there were 1,523 incidents in which dispatched NEPT crews subsequently assessed the patient as requiring transport by emergency ambulance.[[68]](#footnote-69)
	+ Such incidents occur when pre-assessments do not correctly identify patient acuity,[[69]](#footnote-70) or the patient further deteriorates after a NEPT service is dispatched. In such instances, NEPT crews will provide interim care until an emergency ambulance arrives.
* In the case of low acuity patients, NEPT providers may be inappropriately assigned to transport patients who could safely be transported through other means.
	+ Alternative means include transport provided by family, accessible taxis and ride-sharing services,[[70]](#footnote-71) or non-clinical community transport services.
	+ Community transport services are funded by local councils and the Department of Health, which contract the Australian Red Cross to deliver 60,000 transports per year.[[71]](#footnote-72)
	+ In recent years, the supply of community transport services has shrunk, in part due to reductions in funding by local councils, and in part due to the impact of the pandemic on volunteer-based workforces.
* The right financial incentives may not be in place to ensure that patients are always connected with the right transport for them.
	+ AV funds NEPT providers on a per-shift basis which has advantages for unplanned NEPT, but does not reward providers for maximising transfer volumes.
	+ HSV contracts used by health services fund NEPT providers both on a per-shift basis and on a per transport basis, with the latter meaning that transports are still paid for even if patients do not meet the threshold for a NEPT response.

**Consultation questions – *Growth in demand***

* What measures could be taken to ensure NEPT services are appropriately authorised and booked?
* How could the assessment of patient needs (acuity) be improved?
* To what extent do sectors beyond NEPT need to change to address excess demand and pressures on the NEPT sector?

## There is insufficient supply to meet surging demand

* This rapid increase in NEPT demand has not been met by a corresponding increase in supply. This has led to collection delays and increasing rates of spillbacks as described in Section 3.2.
* These problems are due to several factors.
	+ Supply constraints: demand has surged during the pandemic, but there are long lead-in times to secure specialist vehicles and equipment which are required to meet the standards set out in the regulations. In addition, workforce shortages pose a significant challenge to capacity.
	+ Investment uncertainty: while the aim of this review is to strengthen the sector and provide long term certainty on reform directions, it is recognised that the announcement of the review has generated uncertainty for the sector, with implications for planning and managing future investment.
* Supply gaps have particularly impacted rural areas, where providers are struggling with diseconomies of scale.

**Consultation questions – *Insufficient supply***

* What actions could be taken to resolve gaps in supply, given current constraints?

## DH could better exercise its system steward role

* DH is the steward of Victoria’s public health system. It is responsible for setting system strategy and direction, and using its various levers to drive system delivery against strategy.
* These levers are expansive, and include system and workforce planning, operational policy, service design, regulation, funding, performance management, and reform and improvement support.
* In recent years, DH has strengthened its role in the NEPT market, in particular with the regulatory changes described in Section 3.1 above. This has been accompanied by improved engagement with the sector through regular sector forums, communiques, and phone calls.
* However, in terms of procurement and commissioning DH has fully devolved its role in relation to NEPT to HSV, AV and public health services. It does not play a strategic commissioning role in relation to the sector, despite the significant opportunity to shape it using the $155 million in funding annually (albeit indirectly) provided to it.
* This has contributed to missed opportunities to drive efficiencies, including by improving coordination across AV, health services and HSV to reduce complexity and duplication and drive economies of scale.
* As Section 5.2 shows, other jurisdictions have undertaken significant structural reform and operational improvements of their own NEPT system to improve performance. To date Victoria has not pursued similar reform or improvement, beyond regulatory change.

**Consultation questions –*System stewardship***

* How can the department use its role as system steward to create the best conditions for an effective NEPT market?
* How else can the Department positively influence the NEPT sector and associated challenges?

## There is a lack of coordinated workforce planning for NEPT

* Workforce planning, development, and coordination across the NEPT sector remains the responsibility of individual providers with limited state-wide coordination and planning at present.
* This contrasts to the workforce planning and development undertaken by AV for paramedics. With just under 5,000 on road clinical staff concentrated in one organisation, AV can undertake coordinated planning and recruitment for the sector – recruiting 716 paramedics in 2021-22 alone. This scale also provides the opportunity to trial new service models, roles, and career development pathways.[[72]](#footnote-73)
* While the expected knowledge and training requirements for the NEPT workforce are laid out in Clinical Practice Protocols, DH does not play a substantive role in supporting the attraction, development, or retention of the NEPT workforce – this remains the responsibility of providers.[[73]](#footnote-74)
* This limits opportunities for coordinated career development and growth across the wider NEPT and paramedical sector.[[74]](#footnote-75) This gap is heightened by the fact that approximately 85% of the NEPT workforce are under casual employment arrangements.[[75]](#footnote-76)

**Consultation questions – *Improve workforce planning***

* What steps could be taken to improve workforce planning across the NEPT sector?
* What changes to workforce conditions would have the greatest impact in reducing attrition and attracting people to join the sector?

## Low acuity NEPT patients are not always connected with the right transport for their needs

* There is often a misalignment between true patient acuity and services delivered, which can result in ‘overservicing’, increasing costs and bottlenecks across the system.
* This section discusses two forms of ‘overservicing’
	+ inappropriate over-servicing, where low acuity patients are assigned medium acuity NEPT responses
	+ appropriate over-servicing, where the crewing mix meets the regulations but could exceed what a patient requires (for example, low acuity patients are assigned a two-clinician low acuity NEPT response, which is required under the regulations but may not be needed in all cases).

### Low acuity patients often inappropriately receive a medium acuity NEPT response

* Overservicing has multiple causes:
	+ the clinical thresholds between low, medium and high acuity are not clearly articulated and there are reports of mixed interpretations across the industry (particularly for low acuity patients)
	+ there is limited validation of patient needs via acuity assessments during the booking process. In the case of bookings made via ESTA, all planned NEPT requests are accepted regardless of how the requestor answers the standardised questions.[[76]](#footnote-77)
* The inappropriate identification of patients as medium acuity during the intake/booking stage leads to the dispatch of medium acuity NEPT services when follow-up assessments determine cases are actually low acuity.
	+ medium and high acuity patients require active management or intervention, whereas low acuity patients only require visual monitoring
	+ due to their higher complexity, medium and high acuity transports must be single loaded (whereas two low acuity patients can be multi-loaded) and staff must receive additional training in defibrillator operation and electrocardiogram interpretation
	+ this results in a higher service response than necessary and an inefficient use of resources.
* As a result of this inaccurate assessment of acuity, all AV baseload shifts are staffed to medium acuity levels. AV estimates that, if properly assessed, up to 90% of booked cases may be low acuity.[[77]](#footnote-78) This contrasts to the relatively low reported incidence of NEPT transfers, which upon crew arrival, are reported to be of higher acuity than noted on dispatch (around 3,053 incidents in 2021-22).[[78]](#footnote-79)
* The combination of these findings has resulted in a reorganisation of the ESTA booking process and the implementation of an online booking form in early 2023. It is anticipated that this process will more accurately determine patient acuity and deliver services on that basis, rather than being at the discretion of booking health service for example.

### Crew composition may not be optimal

* Across jurisdictions there are a range of models for staffing NEPT services.
	+ In Victoria, the NEPT regulations require patients to always be transported by two trained crew members, with one traveling in the patient compartment with the patient.[[79]](#footnote-80) Both crew members must have skills, competencies and knowledge appropriate for ensuring that the patient's clinical needs can be met for the duration of the transport.[[80]](#footnote-81)
	+ In some jurisdictions such as New South Wales, a different model is followed where one crew member may be a driver with minimal training, [[81]](#footnote-82) while the other is clinically trained at PTO level or above (see case study below).

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| **Case Study: Crew Composition in New South Wales[[82]](#footnote-83)*** NEPT provision in New South Wales is split across three classes (B-D). Class B patients are the most acute patients managed by NEPT in NSW and may require active treatment during transfer. Class D patients are the least acute – they are not anticipated to require active treatment and have a low risk of deterioration during transport.
* Across each of these three categories minimum staffing levels require at least one clinically trained crew member and one driver for the NEPT transfer.
* Across all NEPT classes, the driver may be a PTO, a trainee PTO or a driver (whose minimum training requirement is an appropriate driving license).
 |

* While Victoria’s requirement for two trained crew members to accompany NEPT patients plays an important role in ensuring safe transfers for some patients, there may be some instances where it is no longer necessary for the second crew member (the driver) to have training related to patient care when transporting low acuity patients.[[83]](#footnote-84)
	+ Contemporary technology now enables the crew member travelling in the patient compartment to be remotely assisted, should it be needed, by specialist clinicians. For example, the Victorian Virtual Emergency Department (VVED) offers a dedicated pathway for AV staff to rapidly access the service when infield.
	+ This pathway would inevitably give NEPT crew members access to more highly skilled clinical advice (from doctors and nurses trained in specialist medical fields) than a peer NEPT worker in the vehicle.
	+ Virtual support would offer a third (or more) pair of hands, and enable the driving crew member to focus on bringing the patient safely to hospital without delay or distraction.
* Exceptions to this approach may involve:
	+ transfers in rural and regional areas, where there is a risk of mobile phone blackspots
	+ unplanned NEPT, where patient assessment has occurred over the phone rather than in-person by an authorised clinician, with a greater risk the patient proves more complex than anticipated.
* Any changes to these staffing requirements would need to be carefully considered for any potential risk to patient safety and guardrails to manage this, alongside broader potential benefits to the system such as mitigated supply constraints.

**Consultation question – *connecting patients to the right transport***

* What steps could be taken to ensure patients are connected to the most appropriate transport for their needs?
* What is the appropriate crew skill-mix in lower acuity NEPT transfers?

## There are barriers to competition under existing arrangements

* When public NEPT services were privatised in 1993 (see Section 2.8), it was anticipated that increased competition in the marketplace would drive up efficiency and value for purchasers of NEPT services.
* There are some signs that this is the case, as competition has supported competitive pricing across NEPT providers with reported cost savings for purchasers, even if at times it occurs at the expense of the financial viability of the provider and/or pay and conditions for the workforce.
* However there are some intrinsic challenges which limit the competitiveness of the marketplace.
* First, there are barriers to market entry, due to the high capital and logistic costs of setting up as a new provider. There has only been one new entrant to the NEPT market in the past five years, and this entrant has not claimed a significant share of the market.
* Second, there are switching costs for purchasers.
	+ Health services contracting directly with a private provider are required to align with and adopt that provider’s booking procedures and practices.
	+ Any move to a new provider, or any attempt to work with multiple providers, requires investment from the NEPT purchaser to train their staff and adopt new booking processes and procedures.
	+ In order to move to a new provider, or adopt multiple providers, health services must consider the cost and implications of retraining and updating staff knowledge and local procedures against and potential cost savings.

**Consultation questions – *Barriers to competition***

* How can competitiveness within the NEPT sector be improved, either within the current model or under alternative arrangements?

## There is limited use of contemporary technology

* Compared to other jurisdictions and sectors, use of contemporary technology is relatively limited in the NEPT sector. For example,
	+ health services awaiting NEPT collections and drop-offs have no visibility of the expected arrival time of a vehicle, in contrast to widely available tracking technology most Australians enjoy from other transport and logistics services (for example, Australia Post and other delivery services; Uber, taxis and other ride sharing services), and to the NSW NEPT system which has had two-way tracking since 2014 (see Section 5.2)
	+ system-wide NEPT data collections are minimal, in contrast to other jurisdictions (for example, the NHS which has just introduced a national collection – see Section 5.2) able to use these data to analyse and improve service performance (for example, like NSW which has built a NEPT simulation model to reduce use of alternative providers and lower costs).
* Investment in technology has transition costs, with providers (and often users) needing to redesign workflows and systems, train staff to use them, and invest and maintain capital.
* These investments have longer-term benefits but are challenging to offset against a small revenue base for low-volume providers, or to finance when there is longer-term uncertainty about the future of the sector.

**Consultation questions – *Use of contemporary technology***

* What technological investments would most improve the performance of the NEPT sector?
* How can these be realised?

## The NEPT sector is not well-positioned to meet future needs

* This discussion paper has described the key challenges and strengths impacting the NEPT sector’s ability to meet the needs of patients, the workforce, and the broader health system.
* The NEPT sector delivers high-quality services to Victorian patients and plays a critical role in the health system. Victoria’s uniquely competitive NEPT marketplace helps to ensure NEPT purchasers are able to access these services at a lower cost.
* Recent regulatory reform has encouraged best practice quality and safety by setting minimum standards and compliance mechanisms. NEPT providers have worked hard and invested resources to comply with these new standards and ensure the continued quality and safety of their NEPT services.
* At the same time, market fragmentation, diseconomies of scale and duplicated overheads create inefficiencies in the system. These add costs, which have been recently exacerbated by high inflation, pressures from the COVID-19 pandemic, and the 2021 regulatory changes.
* It has been observed that excess demand for NEPT services, coupled with overservicing in certain areas, has led to an insufficient supply of NEPT services for patients who most need the service. This limits their ability to easily access essential services.
* These supply and demand issues have significant flow-on effects across the health system. When NEPT cases ‘spill-over’ into emergency services it detracts from AV’s ability to deliver responsive emergency care and can cause delays for those most urgently in need. Where there are blockages to admitting and discharging patients, this has a cascading impact on patient flow across individual services and the overall health system.
* At the core of Victoria’s NEPT services is a skilled NEPT workforce dedicated to delivering quality patient care. The majority of the NEPT workforce are under casual contract arrangements which create financial vulnerability for individuals and families, and limits career development opportunities.
* In summary, while there are considerable strengths of the NEPT sector under current arrangements, there is also significant room for improvement to advance access, efficiency, quality, safety, financial and environmental sustainability, and patient and workforce experience.

# What are the future options for reform?

## There are many opportunities to strengthen the NEPT sector

* The questions outlined in this review ask respondents to consider the opportunities for reform and improvement to deliver better outcomes for patients, health service operations, and the experience of the NEPT workforce
* These responses, alongside focused sector engagement and commissioned technical expertise, will help to inform the final recommendations of the review.

### Insourcing is one reform option the review will consider

* One option that will be explored over the course of the review is to transition towards a partial or full in-sourcing model for NEPT service provision.[[84]](#footnote-85)
* In-sourcing could take a variety of forms, including:
	+ reintegration of NEPT alongside AV’s existing operations
	+ delivery of NEPT services through another public agency
	+ NEPT services located within a newly established public entity which may commission, regulate, manage and service.
* In-sourcing could potentially involve a combination of the above changes, for example with planned and unplanned NEPT split into separate agencies.
* The review will carefully consider the relative strengths and weaknesses of insourcing approaches, and their broader system impact.

### The review will also explore other improvement opportunities

* Alternatively, there are several options for reform which would retain outsourcing of NEPT whilst strengthening procurement and contracting arrangements to improve efficiency and performance, and deliver broader benefits to patients, the workforce and the system. Some examples are listed below.
* Consolidating contracts within geographic regions:
	+ under current arrangements multiple providers may operate within a local area and make the same / similar trips in the area
	+ consolidating to a single provider per region and/or geographic corridor offers an opportunity to efficiently plan routes and optimise vehicle use (e.g., by reducing the number of empty return trips).
* Offering centralised procurement of assets and delivery of training:
	+ utilising centralised purchasing power to support NEPT providers to procure required assets and deliver workforce training more efficiently.
* Streamlining booking and purchasing arrangements:
	+ identifying opportunities to simplify existing arrangements which include multiple points of access, differing models of governance and oversight, and varying payment mechanisms.
* Exploring social procurement conditions:
	+ opportunities to maximise social procurement across NEPT contracts, including through employment terms and conditions (such as the provision of break and rest facilities when on-shift and reviewing pay and contractual arrangements) and environmental sustainability provisions.

### The review will also explore other improvement opportunities

* Across each of these reform options there is also the opportunity to consider further sector improvements independently of the procurement model. Some examples are listed below.
* Improved scheduling and coordination models to improve efficiency, including:
	+ exploration of options to decrease the ratio of planned NEPT services booked on the day of travel, and
	+ consideration of a reservation-style scheduling that optimises pick-up and drop-offs on the same route.
* Matching NEPT service provision to patient acuity:
	+ options to reduce over-servicing by AV and health services for patients who need a lower-acuity service than the one provided
	+ revisiting crewing requirements for low acuity patients
	+ growing the role of the community transport sector to provide transport in cases where NEPT is not required.
* Reducing emissions: with a large fleet covering significant distances, there are opportunities to improve the sector’s environmental sustainability through fleet renewal and other initiatives.
* Improved DH system stewardship: increasing the role and responsibilities of DH in relation to strategic planning, commissioning and procuring NEPT services, including through more active coordination of funded agencies purchasing NEPT services to achieve strategic aims.

## Victoria can also learn from reforms in other health systems

* In recent years, other health systems have conducted reviews and reform initiatives that have considered the quality and effectiveness of NEPT provision.
* In Australia, NEPT reform initiatives have included development of automated scheduling and dispatch systems, patient transport simulation models, and patient access coordination hubs.
	+ In 2014, New South Wales began the process of separating emergency and non-emergency transport services. This led to the development of the Patient Transport Service (PTS) which has an **automated scheduling and dispatch system** allowing for real-time two-way tracking of services (see Box 2).
	+ In 2018, New South Wales commissioned the development of a **patient transport simulation** model to reduce the use of alternative service providers. The model optimised transport routes and identified 48 journeys per week that could be accommodated within the core HealthShare NSW capacity by adding 176 vehicle hours, resulting in reduced costs of the services overall (see Box 3).
	+ Since 2017, Queensland Health has continued the expansion and roll-out of the **Patient Access Coordination Hub** (PACH) model. The PACH enhances operational performance and assist with patient flow using a real-time intelligence system. This provides visibility of the patient journey, facilitating interhospital transfers and planned transport across the health system (see Box 4).
* In the United Kingdom, a review led to the establishment of a national framework for non-emergency patient transport.
	+ In 2021, the NHS review in the United Kingdom set out a **national framework** to ensure a responsive, fair, and sustainable patient transport sector. Following a public submission process, an updated eligibility criteria was published and included a universal commitment of transport support for patients attending in-centre haemodialysis. In addition, a national patient transport dataset has been established to monitor performance of the sector (seeBox 5*).*

Box 2: New South Wales (Australia) case study – Greater Metropolitan Hub

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| **Case Study: Automated scheduling and dispatch service for New South Wales 2014[[85]](#footnote-86)*** The Greater Metropolitan Hub centralises the scheduling and coordination of Patient Transport Services (PTS) in greater metropolitan Sydney and Hunter New England.
* The technology handles routine scheduling and dispatching by reviewing the capabilities, availability and location of patient transport vehicles, and scheduling the optimal combination of transport. This auto-scheduling is based on rules defined by the PTS and allows the booking hub team to focus on any transports that fall outside the ‘norm’ and communicating with health services to facilitate the request.
* The Greater Metropolitan Hub has been integrated with the existing Patient Flow Portal used by NSW Health facilities. The real-time information sharing allows clinicians and administrators to track the status of the request, and reduces the number of phone calls and miscommunication that previously occurred. This system was developed in partnership between PTS leaders and Logis Solutions.
 |

Box 3: New South Wales (Australia) case study – Patient transport simulation model

|  |
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| **Case Study: A patient transport simulation model for New South Wales 2018[[86]](#footnote-87)*** In 2018, HealthShare NSW commissioned operational researchers to explore resourcing options for its PTS. In 2016/17, the PTS delivered 200 patient transports per week with 492 vehicle hours. Over this period, the PTS were unable to keep up with demand and subsequently passed on the request to alternative providers at great additional cost.
* A patient transport simulation model was developed, considering factors such as vehicle type and crew mix, shift patterns, and the distribution and volume of patient journeys. An algorithm was developed to generate vehicle routes, and was improved using a ‘cost function’ to determine the ‘better’ route (including factors such as impacts on patient care and timeliness).
* The model showed that there were an additional 60 journeys per week which were given to alternative services, and by adjusting the simulation, 80% of these journeys could be accommodated within the core HealthShare capacity by adding 176 vehicle hours. As a result, the additional cost of using alternative providers has significantly decreased.
 |

Box 4: Queensland (Australia) case study – Queensland Patient Access Coordination Hub[[87]](#footnote-88)

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| --- |
| **Case Study: Queensland Patient Access Coordination Hub** * Since 2017, Queensland has been implementing Patient Access Coordination Hubs (PACH) across the state. The PACH model was designed to enhance operational performance and assist with patient flow using real-time intelligence. Visibility is provided across the patient journey from ambulance operations, through to the emergency department, to admission and subsequent discharge.
* The PACH is staffed by Queensland Ambulance Services (QAS) and Queensland Health officers who collaborate and use real-time data to make informed decisions that assist in the management of the patient journey, whilst enhancing the coordination of patient flows.
* The technology enables both planned and real-time visibility of interfacility transfers and medically authorised transports to health facilities. This has increased patient flow into the community, improved ED capacity and patient flows within hospitals.
 |

Box 5: NHS (United Kingdom) case study – National framework to support NEPTS

|  |
| --- |
| **Case Study: NHS Improving non-emergency patient transport services report 2021[[88]](#footnote-89)**The 2021 Review of Non-Emergency Patient Transport Services (NEPTS) in the UK set out a new national framework to support the aim of NEPTS becoming more responsive, fair and sustainable. The framework has five components:* More consistent patient eligibility for planned services.[[89]](#footnote-90)
* Support for wider transport planning and journeys for all patients. This recognises the need to integrate NEPTS with health system components and funding schemes beyond NEPTS. Legislative changes to this effect will be introduced shortly.
* Greater transparency on performance to drive outcomes and enable learning, including articulated key performance criteria. This resulted in the introduction of the first national dataset for NEPTS.[[90]](#footnote-91)
* A staged path to net zero carbon emissions for the NHS patient transport sector, with 100% of vehicles used to deliver the contract to be zero-emission vehicles by 2035.
* Improved procurement and contract management, which will include core standards and model specifications across the sector
 |

**Consultation questions – *Future options for reform***

* What are your views on the reform options outlined?
* Which offer the biggest potential benefits for Victorians?
* What is missing from these options?
* What factors need to be considered when implementing any reform options, to ensure feasibility and sustainability, and to manage risk of unintended consequences?
* How can potential solutions account for differences between metropolitan and rural areas?

# Consultation questions and public submissions

## Focus of public submissions

The department invites stakeholders to join the public submission process and provide solution-focused responses. The feedback received from these submissions will be used to inform the advice in the review’s final report to the Victorian Government.

We strongly encourage respondents to focus submissions on the key questions outlined in this discussion paper and potential options for reform. While a range of different issues have been raised in the discussion paper, stakeholders are encouraged to focus on the questions that are most relevant to them.

## Summary of questions

The consultation questions provided throughout the document are summarised in Table 5 below for convenience.

**Table 5: Summary of consultation questions**

| Section | Consultation questions |
| --- | --- |
| How are NEPT services set up in Victoria? | * Have the essential features of the Victorian NEPT sector been captured in this chapter?
* What additional features of the sector do you feel are important for the review to consider?
 |
| How is the sector currently performing? | * Do you agree with the summary of the key strengths and current challenges facing the NEPT sector that has been outlined in this discussion paper?
* Are the current quality and safety standards for NEPT services in Victoria appropriate for the sector, and appropriately enforced?
* Does this discussion paper fairly reflect the pressures on timeliness and costs of NEPT services?
* Have the sector’s environmental impacts and policies been fully captured?
* Have the issues regarding workforce pay and conditions been fairly reflected?
 |
| Market fragmentation drives up costs and slows down transfers | * What are the most appropriate options for addressing the existing challenges of complexity, duplication, and inefficiency associated with market fragmentation?
* What other examples can be drawn upon to guide best practice in this area?
* Which changes would have the biggest impact on the environmental sustainability of the sector, and create efficiencies enabling reinvestment?
 |
| There is excess demand, not all of it appropriate | * What measures could be taken to ensure NEPT services are appropriately authorised and booked?
* How could we improve the assessment of patient acuity?
* To what extent do sectors beyond NEPT need to change to address excess demand and pressures on the NEPT sector?
 |
| There is insufficient supply to meet surging demand | * What actions could be taken to resolve gaps in supply, given current constraints?
 |
| DH could better exercise its system steward role | * How can the department use its role as system steward to create the best conditions for an effective NEPT market?
* How else can the Department positively influence the NEPT sector and associated challenges?
 |
| There is a lack of coordinated workforce planning for NEPT | * What steps could be taken to improve workforce planning across the NEPT sector?
* What changes to workforce conditions would have the greatest impact in reducing attrition and attracting people to join the sector?
 |
| Crew composition may not be optimal  | * What steps could be taken to ensure patients are connected to the most appropriate transport for their needs?
* What is the appropriate crew skill-mix in lower acuity NEPT transfers?
 |
| There are barriers to competition under existing arrangements | * How can competitiveness within the NEPT sector be improved, either within the current model or under alternative arrangements?
 |
| There is limited use of contemporary technology | * What technological investments would most improve the performance of the NEPT sector?
* How can these be realised?
 |
| Future options for reform  | * What are your views on the reform options outlined?
* Which offer the biggest potential benefits for Victorians?
* What is missing from these options?
* What factors need to be considered when implementing any reform options, to ensure feasibility and sustainability, and to manage risk of unintended consequences?
* How can potential solutions account for differences between metropolitan and rural areas?
 |

# Next Steps

## Process and timelines

* All NEPT sector stakeholders are invited to participate in the public submission process and wider sector engagement that will take place over the coming weeks.
* Responses to the consultation, alongside wider sector engagement and independent technical analysis, will inform the final review report and accompanying recommendations that will be presented to government by December 2023 in line with the review’s terms of reference.
* Further updates will be made available over the course of the review through <https://www.health.vic.gov.au/patient-care/non-emergency-patient-transport-review>

Table 6 Indicative timelines for NEPT review

|  |  |
| --- | --- |
| **Milestone** | **Date** |
| Release of discussion paper | 31 May 2023 |
| Close of public submission process | 14 July 2023 |
| Sector engagement  | June - July 2023 |
| Independent options analysis | August 2023 |
| Report to government | December 2023 |

**Contact details**

For further information, please contact neptreview@health.vic.gov.au

# Appendices

## Appendix 1: Abbreviations

|  |  |
| --- | --- |
| AAVARV | Air Ambulance VictoriaAdult Retrievals Victoria |
| ATA | Ambulance Transport Attendant |
| AV | Ambulance Victoria |
| CCRN | Registered Nurse Critical Care |
| CSO | Community Service Obligation |
| DH | Department of Health (Victoria) |
| DVA | Department of Veterans’ Affairs (Commonwealth) |
| EBA | Enterprise bargaining agreement |
| EN/EEN | (Endorsed) Enrolled nurse division 2 |
| ESTA | Emergency Services Telecommunications Authority  |
| HIP | Health Independence Programs |
| HSV | HealthShare Victoria |
| HTS | Health Transport Services (Tasmania) |
| MAS | Metropolitan Ambulance Services (former) |
| NEPT | Non-Emergency Patient Transport |
| PACH | Patient Access Coordination Hub (Queensland) |
| PIPER | Paediatric Infant Perinatal Emergency Retrieval  |
| PTO | Patient Transport Officer |
| PTS | Patient Transport Service (New South Wales) |
| RN1 | Registered Nurse Division 1 |
| TAC | Transport Accident Commission |
| VAU | Victorian Ambulance Union |
| VWA | Victorian WorkCover Authority |
|  |  |
| the Act | *Non-Emergency Patient Transport and First Aid Services Act 2003* |
| the Regulations | Non-Emergency Patient Transport Regulations 2016 (incorporating 2021 amendments) |

##

## Appendix 2: Jurisdictional comparison of procurement arrangements

| **Jurisdiction & service name** | **Contract administrator** | **Type of contract** | **Provider/s** | **Key legislative instruments and/or policies** | **Funding approach** | **Summary of patient transport servicing across regions** |
| --- | --- | --- | --- | --- | --- | --- |
| **Victoria**NEPT | Victorian Department of Health  | Service agreement with statutory body, who then administer private provider contractsOther contracts  | AV via 6 private providersHSV via 4 private providersIndividual health services | *Non-Emergency Patient Transport Act 2003* | Block grant (AV)NWAU (health services)  | Multiple providers in almost every region of Victoria  |
| **Tasmania**Health Transport Services (HTS) | Ambulance Tasmania (Department of Health Tas) | Service agreement with statutory body, and administers private provider contracts for overflow service | Ambulance Tasmania (mainly)5 private providers[[91]](#footnote-92) | *Ambulance Services Act 1982* | Costs met by Tasmania Government based on NWAU | HTS is an integrated state-wide service operating from five geographical stationsFive private providers exist as an overflow service for Ambulance Tasmania |
| **Western Australia**NEPT | West Australian Department of Health | Panel Contract | 3 private providers (National Patient Transport Group, St John Ambulance Australia, Wilson Medic One) | Road-based Inter-Hospital Patient Transport Services Policy 2021 | Costs met by the WA Government; funded by the ordering/ sending hospital (as part of Panel Contract)  | Metropolitan services can choose from 3 providers (for low & medium acuity patients)[[92]](#footnote-93)All high acuity road based inter-Hospital NEPT & WA Country Health Services must purchase from one provider (St John Ambulance Australia) |
| **Northern Territory**Patient Transport Service | Northern Territory Government | Service agreement with private provider | 1 private provider (St John Ambulance) | *Northern Territory of Australia Medical Services Act 2018* | Costs met by NT Government  | Provides state-wide service, with five bases across Northern Territory. Bases in Darwin and Alice Springs have hoist vehicles with additional seats for passengers [[93]](#footnote-94) |
| **South Australia** SA Ambulance Patient Transport Services | Department for Health and Wellbeing (SA Health) | Service agreement with statutory body\*\**May accredit private providers* | SA Ambulance Service  | *Health Care (Governance) Amendment Act 2021* | Costs incurred by patient (user-pays service, with subsidises available for concession card holders) | Provides state-wide services, with several base stations across South Australia |
| **Queensland**Non-emergency medical transport | Queensland Health & Department of Community Safety | Service agreement with statutory body\* | Queensland Ambulance Service\* | The Ambulance Service Regulations 2015 | Costs met by the Queensland Government | Provides state-wide services across eight geographical regions; through 8 Operations Centres responsible for emergency call taking, operational deployment and dispatch, and coordination of non-urgent patient transport services[[94]](#footnote-95) |
| **New South Wales**Patient Transport Services | NSW Health | Service agreement with statutory body | HealthShare NSW\* | *Health Services Amendment (Ambulance Services) Act 2015*Service Specifications for Transport Providers, Patient Transport Service 2018 | Costs met by the NSW Government | Provides state-wide services across greater metropolitan Sydney and Hunter New England.The Greater Metropolitan Booking Hub coordinates the booking and dispatching of non-urgent NEPT bookings in greater metropolitan Sydney and Hunter New England.The Greater Metropolitan Booking Hub also provides technical and after-hours operational support to Regional Satellites in Port Macquarie, Tamworth, Dubbo, Wagga Wagga and Goulburn[[95]](#footnote-96) |
| **Australian Capital Territory**NEPT | ACT Emergency Services Agency (part of ACT Government)  | N/A | ACT Ambulance (operational service of ACT Emergency Services Agency) | Emergencies Act 2004 | Costs met by the ACT Government | Provides services across the jurisdiction  |

1. On 14 April 2023, the Victorian Government released the terms of reference for a review of non-emergency patient transport services in Victoria. <https://www.health.vic.gov.au/patient-care/non-emergency-patient-transport-review> [↑](#footnote-ref-2)
2. a registered medical practitioner, a registered nurse, or a registered paramedic. [↑](#footnote-ref-3)
3. Source: Victorian Department of Health. (2021). *Non Emergency Patient Transport Regulations 2016 (incorporating 2021 amendments).* <https://www.health.vic.gov.au/patient-care/nept-legislation-and-clinical-practice-protocols> [↑](#footnote-ref-4)
4. NEPT transfers by air are carried out by the Royal Flying Doctor Service. Air Ambulance Victoria services are focussed on emergency response [↑](#footnote-ref-5)
5. such as outpatients, radiological, cancer treatment and other specialist appointments. [↑](#footnote-ref-6)
6. For example, community transport servicing low acuity/non-clinical non-urgent cases. In addition, the Department of Health has a contract with Red Cross to provide medically necessary transports, for vulnerable cohorts who do not qualify for NEPT but have no other transport options. [↑](#footnote-ref-7)
7. Source: Emergency Management Victoria. (2017). *Emergency Management Victoria Operational Review 2016-17.* <https://www.emv.vic.gov.au/publications/emergency-management-operational-review-2016-17> [↑](#footnote-ref-8)
8. Source: NEPT provider annual reporting 2021-22 collected by the Department of Health [↑](#footnote-ref-9)
9. Source: Ambulance Victoria (2022) *Ambulance Victoria Annual Report 2021-22*, at <https://www.ambulance.vic.gov.au/wp-content/uploads/2022/12/Ambulance-Victoria-Annual-Report-2021-22.pdf> [↑](#footnote-ref-10)
10. Source: NEPT provider annual reporting 2021-22 and AV reported figure [↑](#footnote-ref-11)
11. Source: NEPT provider annual reporting 2021-22; Ambulance Victoria Annual Report 2021-22 [↑](#footnote-ref-12)
12. NEPT providers report these pathways exacerbate the recruitment pressures they face, particularly in rural areas, as discussed in Section 4.3. [↑](#footnote-ref-13)
13. Currently, NEPT practitioners can administer five Schedule 4 medicines (Amiodarone, Ipratropium, Methoxyflurane, Ondansetron, Salbutamol). Administration of Schedule 8 medications is not currently a clinical option for NEPT staff under the Clinical Scope of Practice. [↑](#footnote-ref-14)
14. Non-Emergency Patient Transport Clinical Practice Protocols 2023 edition, Department of Health [↑](#footnote-ref-15)
15. Non-Emergency Patient Transport Clinical Practice Protocols 2023 edition, Department of Health [↑](#footnote-ref-16)
16. Section 5 of the NEPT Act makes it an offence for a person or a body corporate to operate a NEPT service unless they hold a licence and section 13 provides the Secretary of the Department of Health the authority to grant a NEPT license. The Act also provides inspection and enforcement powers to authorised officers, to require providers of NEPT services to produce vehicles and documents for inspection, for the purpose of monitoring compliance with the NEPT Act and regulations. [↑](#footnote-ref-17)
17. There is no provision for issuing infringements within the Act or Regulations. [↑](#footnote-ref-18)
18. Victorian WorkSafe patients, Department of Veterans’ Affairs Gold Card or White Card holders and Transport Accident Commission patients are not charged for NEPT services – the relevant programmes are invoiced in line with Ambulance services payment guidelines [↑](#footnote-ref-19)
19. Both AV and health services engage private providers to meet most of their NEPT needs – see Section 2.5 below. Some health services use their own vehicles for certain transfers (e.g., between campuses) but this is comparatively rare. [↑](#footnote-ref-20)
20. In 2015-16, a six-month pilot study was run involving three health services that trialled simplified purchasing arrangements for planned NEPT. Funding for concession patients was reassigned from AV to health services when transferring patients to the community. Under this arrangement, health services could select their preferred NEPT provider, rather than being required to use AV. While there were overall efficiencies during the pilot, on-time performance was mixed, declining by 5% for pre-booked transfers but improving by 9% for same-day transfers. While there were significant cost saving for pilot sites, this may not fully capture the true cost differential. [↑](#footnote-ref-21)
21. This table excludes private health services. In all planned NEPT cases, health services have responsibility for booking NEPT services. Depending on the circumstances listed above, health services will either purchase NEPT services directly from the private market or request services through the ESTA booking system where AV is the purchaser. Further detail on payment responsibilities can be found here: <https://www.health.vic.gov.au/patient-care/ambulance-services-payment-guidelines> [↑](#footnote-ref-22)
22. Source: NEPT provider annual reporting 2021-22 [↑](#footnote-ref-23)
23. In addition, some private hospitals (such as Epworth Healthcare - one of the 13 licensed providers in Victoria) runs an in-house fleet. [↑](#footnote-ref-24)
24. For example, hospitals may maintain their own small fleet to manage transfers between their own campuses. [↑](#footnote-ref-25)
25. Source: Department of Health (2021). *NEPT Regulations 2021 Regulatory Impact Statement,* p. 22 [↑](#footnote-ref-26)
26. The ESTA process is underpinned by The Transport Framework which is a set of workflows used during the booking process to confirm the clinical state of the patient and identify the most appropriate transportation platform. [↑](#footnote-ref-27)
27. which automatically generates assessment of patient acuity [↑](#footnote-ref-28)
28. More than half of Victorian NEPT providers (8 of 13) supply first aid services at community events. Source: Licensed First Aid Services 2021-22 annual reporting collected by the Department of Health [↑](#footnote-ref-29)
29. Source: ACIL Allen Consulting (2013), *The NEPT Review Final Report*, p. 23 [↑](#footnote-ref-30)
30. Source: Higgins, C & Shugg, D (2008). *Non Emergency Patient Transport in Victoria: An* overview. Journal of Emergency Primary Health Care 6(4). <https://ajp.paramedics.org/index.php/ajp/article/view/473/473> [↑](#footnote-ref-31)
31. Specific changes in 2021 included: all medium and high acuity patient transports must be single loaded, all stretcher vehicles must be fitted with power lift stretchers only, life limits on NEPT vehicles cannot exceed 400,000kms and increased requirements for workforce skills maintenance. [↑](#footnote-ref-32)
32. AV put out its first state-wide tender to outsource NEPT services to private providers in 2012. Prior to this, there was no coordinated process for AV to purchase NEPT from the private market. Source: ACIL Allen Consulting, *NEPT review*, p. 37. [↑](#footnote-ref-33)
33. This non-operation arose from the abolishment of accreditation for ‘standby’ services for NEPT through the 2021 reforms. [↑](#footnote-ref-34)
34. Source: NEPT provider annual reporting 2021-22 [↑](#footnote-ref-35)
35. Source: NEPT Regulations (2021) *Regulatory Impact Statement,* p. 27 [↑](#footnote-ref-36)
36. A ‘red escalation’ is when AV is experiencing a severe impact on normal operations due to extreme workload or demand. Source: Ambulance Victoria, ‘How we manage demand’. <https://www.ambulance.vic.gov.au/community/education/how-we-manage-demand/#:~:text=A%20red%20escalation%20is%20a,to%20extreme%20workload%20or%20demand>. [↑](#footnote-ref-37)
37. Source: Department of Health (2016*), Targeting zero: Report of the Review of Hospital Safety and Quality Assurance in Victoria* <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/research-and-reports/h/hospital-safety-and-quality-assurance-in-victoria.pdf> [↑](#footnote-ref-38)
38. Source: Department of Health (2016) *Better, Safer Care Delivering a world-leading healthcare system* <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/factsheets/b/better-safer-care.pdf> [↑](#footnote-ref-39)
39. In Victoria sentinel events are assigned an incident severity rating (ISR) on a scale of one to four that guides the level of investigation required. Sentinel events (often referred to as ‘never events’) are ISR level 1 incidents, which result in the death of, or serious physical or psychological injury of a patient. [↑](#footnote-ref-40)
40. ISR level 2-4 adverse events. [↑](#footnote-ref-41)
41. Source: advice from Safer Care Victoria. [↑](#footnote-ref-42)
42. This figure is limited to adverse events where the provider perceives that they have primary carriage of an incident. Where it is attributed to issues relating to AV call-taking/dispatch, or where clinical care is provided by another health service, it is unlikely that the adverse event will be reported to the department. [↑](#footnote-ref-43)
43. Source: NEPT provider Annual Reporting 2021-22. The remainder of the reported events were vehicle accidents and staff injuries that were not distinguished from patient safety events in provider reporting. [↑](#footnote-ref-44)
44. Source: Department of Health internal analysis [↑](#footnote-ref-45)
45. Secondary analysis of AV emergency spills data [↑](#footnote-ref-46)
46. Secondary analysis of AV emergency spills data [↑](#footnote-ref-47)
47. Source: Ambulance Victoria, ‘Environment’. <https://www.ambulance.vic.gov.au/about-us/sustainability/environment/> [↑](#footnote-ref-48)
48. Source: Department of Health (2021) *Non-Emergency Patient Transport Amendment Regulations 2021 Regulatory Impact Statemen*t, p. 78 [↑](#footnote-ref-49)
49. The Victorian Sick Pay Guarantee pilot programme pays eligible casual or self-employed workers up to 38 hours of personal and/or carer’s pay. The pilot focuses on the industries with some of the highest rates of casual and contract workers who do not have access to sick pay, whose work hours are often unpredictable and low paid, and where vulnerable groups are overrepresented, such as people from culturally and linguistically diverse backgrounds, women and young people. While the NEPT workforce is not eligible, the scheme will be evaluated and eligibility reviewed following the pilot. [↑](#footnote-ref-50)
50. Casual employees are however entitled to long service leave, under the Long Service Leave Act (2018). See: https://www.vic.gov.au/long-service-leave [↑](#footnote-ref-51)
51. Source: Fair Work Commission (2020), *Ambulance and Patient Transport Industry Award 2020*, Ch.11 [↑](#footnote-ref-52)
52. National Patient Transport committed in its 2019 enterprise agreement to increase the proportion of permanent employees by 30%. Source: Fair Work Commission (2019) *National Patient Transport Ptd Ltd Victorian Employees Enterprise Agreement 2019*, p.10 [↑](#footnote-ref-53)
53. Even if both providers have contracting arrangements with AV. Similarly, AV employees considering a move to a private provider may also risk losing their entitlements. [↑](#footnote-ref-54)
54. This variation in pay and conditions was illustrated in Victorian Ambulance Union’s (VAU) response to The Royal Commission into Victoria’s Mental Health System. Source: VAU (2019*) Preliminary submission to the Royal Commission into Victoria’s Mental Health System* <http://rcvmhs.archive.royalcommission.vic.gov.au/Victorian_Ambulance_Union.pdf> [↑](#footnote-ref-55)
55. St John’s Ambulance members carried out protected strike action on 5 March 2023. Source: Victorian Ambulance Union (2023). *St John Members Protected Industrial Action FAQs.* <https://vau.org.au/st-john-members-protected-industrial-action-faqs/> [↑](#footnote-ref-56)
56. And single-provider systems also have downsides – including a lack of competitive pressures to keep costs down. [↑](#footnote-ref-57)
57. Source: Department of Health (2022) *Rural public health care agencies’ information and communications technology (ICT) Alliance Policy*  <https://www.health.vic.gov.au/sites/default/files/2022-04/rural-public-health-care-agencies-ict-alliance-policy.docx> [↑](#footnote-ref-58)
58. See Section 2.3 [↑](#footnote-ref-59)
59. Source: Procurement Australia, ‘Health and Care Consumables’. <https://www.paltd.com.au/solutions/health-care> [↑](#footnote-ref-60)
60. But not necessarily exclusive [↑](#footnote-ref-61)
61. Data sourced from HSV NEPT service providers list 2023 [↑](#footnote-ref-62)
62. Source: Ambulance Victoria internal analysis [↑](#footnote-ref-63)
63. St John Ambulance, which also delivers WA’s ambulance services Source: Government of Western Australia, Department of Health (2021) *Road Based Inter Hospital Patient Transport Services Policy* <https://www.health.wa.gov.au/~/media/Files/Corporate/Policy-Frameworks/Purchasing-and-Resource-Allocation/Policy/Road-Based-Inter-Hospital-Patient-Transport-Services-Policy/MP85-Road-Based-Inter-Hospital-Patient-Transport-Services-Policy.pdf> [↑](#footnote-ref-64)
64. For example, failing to double-load patients where it is appropriate to do so. [↑](#footnote-ref-65)
65. AV is required to use HSV for other procurement functions, but is not required to use the HSV NEPT panel as other public health services are. [↑](#footnote-ref-66)
66. Source: Ambulance Victoria internal analysis [↑](#footnote-ref-67)
67. Total growth of Triple Zero calls 2015-2019 Source: Ambulance Victoria [↑](#footnote-ref-68)
68. NEPT provider annual reporting 2021-22 [↑](#footnote-ref-69)
69. ESTA pre-assessments and AV secondary triage (for unplanned NEPT) or an authorised clinician (for planned NEPT) [↑](#footnote-ref-70)
70. For example, Uber Health. [↑](#footnote-ref-71)
71. Source: Australian Red Cross (2022) *Annual Report 2021-22* <https://www.redcross.org.au/globalassets/cms/publications/annual-reports/annual-report-2022.pdf> [↑](#footnote-ref-72)
72. Source: Ambulance Victoria (2022). *Ambulance Victoria Annual Report 2021-22.* [↑](#footnote-ref-73)
73. It should be noted the Victorian Government has recently made the Diploma of Emergency Health Care free of charge. See: <https://www.vic.gov.au/free-tafe> [↑](#footnote-ref-74)
74. Stronger workforce coordination presents an opportunity to link the NEPT and paramedic pathways for those interested in stepping up or down in scope of practice over their career. [↑](#footnote-ref-75)
75. Source: Department of Health (2021). *NEPT Regulations 2021 Regulatory Impact Statement* [↑](#footnote-ref-76)
76. [↑](#footnote-ref-77)
77. For unplanned NEPT transfers, in most cases the patient will not have received an in-person clinical assessment and in these instances it may be appropriate to provide a skill-mix higher than based on the assessed acuity of the patient. [↑](#footnote-ref-78)
78. Source: NEPT provider annual reporting 2021-22 [↑](#footnote-ref-79)
79. Source: Non-Emergency Patient Transport Regulations 2016, incorporating amendments 2021 (Vic) S.R No. 28/2016; section 11(1)(b) [↑](#footnote-ref-80)
80. Source: Non-Emergency Patient Transport Regulations 2016, incorporating amendments 2021 (Vic) S.R No. 28/2016; section 19(1) [↑](#footnote-ref-81)
81. Beyond skills in manual handling, to assist with loading and unloading of patients [↑](#footnote-ref-82)
82. Source: HealthShare New South Wales (2023) *Service Specifications for Transport Providers, Patient Transport Service* <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2018_002.pdf>, p. 7 [↑](#footnote-ref-83)
83. Training related to manual handling would still be necessary. [↑](#footnote-ref-84)
84. noting the small volume of non-contracted NEPT services already provided by AV at present. [↑](#footnote-ref-85)
85. Source: NSW Health (2020). *Patient Transport* Service. <https://www.health.nsw.gov.au/pts/Pages/about-pts.aspx>

Source: Logis Solutions (2015). *NSW Health Patient Transport Service* <https://logissolutions.net/case-studies/new-south-wales/> [↑](#footnote-ref-86)
86. Source: The Operational Research Society (2018). *Improving patient transport in New South Wales.* <https://www.theorsociety.com/resource-centre/business-case-studies/improving-patient-transport-in-new-south-wales/> [↑](#footnote-ref-87)
87. Source: Queensland Government (2022). *Patient Access Coordination Hub*. <https://clinicalexcellence.qld.gov.au/improvement-exchange/patient-access-coordination-hub-pach> [↑](#footnote-ref-88)
88. Source: NHS (2021). *Improving non-emergency patient transport services: Report of the non-emergency patient transport review.* <https://www.england.nhs.uk/publication/improving-non-emergency-patient-transport-services/> [↑](#footnote-ref-89)
89. Under eligibility criteria published in 2022, patients are likely to qualify for NEPTS if they meet one or more of the following: medical needs, cognitive or sensory impairment, significant mobility needs, travelling to use in-centre haemodialysis, concern for their wellbeing has been raised, or wider needs that have resulted in services or discharge being missed or severely delayed. <https://www.england.nhs.uk/wp-content/uploads/2022/05/B1244-nepts-eligibility-criteria.pdf> [↑](#footnote-ref-90)
90. Source: NHS Digital (2022) *Non-Emergency Patient Transport Services (Data Collection) Directions 2022* <https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notices/nhs-england-directions/non-emergency-patient-transport-services-data-collection-directions-2022> [↑](#footnote-ref-91)
91. Source: Parliament of Tasmania (2022) *Report on Rural Health Services in Tasmania* [↑](#footnote-ref-92)
92. This requirement does not apply to Fiona Stanley Hospital and the Rottnest Island Nursing Post. Source: Government of Western Australia (2021) *Road Based Inter Hospital Patient Transport Services Policy*. [↑](#footnote-ref-93)
93. St John Northern Territory (2023) *Ambulance & Patient Transfer*. <https://www.stjohnnt.org.au/services/ambulance-patient-transfer> [↑](#footnote-ref-94)
94. Queensland Government (2023) *Queensland Ambulance Service Regions*. <https://www.ambulance.qld.gov.au/LASN.html> [↑](#footnote-ref-95)
95. Source: NSW Health (2020). *Patient Transport* Service. <https://www.health.nsw.gov.au/pts/Pages/about-pts.aspx> [↑](#footnote-ref-96)