# HEALTH OVERVIEW & SCRUTINY – NON-URGENT PATIENT TRANSPORT

## 1 SUMMARY

1.1 To apprise Members of the outcome of a health overview and scrutiny panel study into non-urgent patient transport for residents of Essex and Thurrock accessing health care at hospitals and day clinics.

1.2 In accordance with the Committee's earlier decision, County Councillor R A Pearson, who is a member of the Panel that undertook the study, has been invited to attend the meeting.

## 2 NON-URGENT PATIENT TRANSPORT STUDY

2.1 Non-urgent patient transport was chosen for the second health overview and scrutiny study in Essex because of its importance to residents in accessing medical care, because of its relevance to national reports dealing with issues such as transport and social exclusion, and because it addressed issues of joint working across health, social care, Local Authorities, voluntary and community organisations.

2.2 The objectives of the study were:-

- To investigate the extent to which transport issues contribute to patients missing health appointments.
- To investigate avoidable inequality of access to health services in a consistently and adequately measured way (e.g. looking at distance, travel time and quality of transport, given clinical condition) and to recommend a minimum acceptable standard of provision.
- To review the extent to which transport issues are featured within the criteria by which facility – siting decisions are taken, and the extent to which these decisions impose costs on patients, relatives and other public bodies. To review the conclusions which are reached and make recommendations about the improvement of these.

2.3 The desired outcome of the study was identified as

*To develop a priority list of areas or facilities in need of transport improvement action to improve access to health facilities and levels of patient satisfaction.*

2.4 A copy of the full report has been placed in the Members' Library. The overall conclusions and recommendations are appended to this report.

## 3 FINDINGS

3.1 These are reported in the context of the three objectives for the review, as explained in paragraph 2.2 above.

### Transport Issues affecting patients missing health appointments

- There is anecdotal evidence that some people are missing health appointments because of transport related reasons. Some 3% of the national population are unable to access healthcare for this reason, and the study has given no reason to doubt that this is not the same in Essex and Thurrock.

- It appears that some free transport is being provided for 'social' rather than medical reasons, but if this transport were to be taken away, it is possible that this would give rise to an increase in missed appointments.

- Lots of factors may contribute to the level of missed appointments or indeed difficulties in accessing healthcare.

- The current criteria for entitlement to free patient transport services are open to local interpretation and as a consequence may have restricted access for some.

- Under the guidance, decisions on eligibility for free non-emergency Patient Transport Services (PTS) should be made by individual GPs, clinicians, dentists and midwives but, in practice, the decision may be delegated to other members of staff such as GP's receptionists.

- Insufficient publicity is given to the hospital travel costs scheme and many patients and healthcare professionals are unaware of its existence. Claiming financial help and receiving reimbursement is often complex and, like PTS, there is confusion over whether a patient is eligible for help. As a result many patients may miss out on the support to which they are entitled.

### Equality of access

- There is no quantitative evidence about the number of people in Essex and Thurrock who have difficulties in accessing healthcare. However, anecdotal evidence suggests that there is a problem and that it may be more serious in certain, mainly rural, parts of the County and amongst the elderly population.

- Anecdotal local evidence shows that PTS is either inaccessible, inappropriate or not available, for certain groups.

- A national study found that 15% of people have difficulty getting to hospital due to transport problems. Another study suggested that people find it harder to get to hospitals than to other key services, with younger adults and the elderly reporting more problems. However, no significant difference was found between rural and urban areas in terms of people reporting problems in getting to hospital.

- National evidence suggests that the car is the main mode of access to hospitals, used by about three quarters of people. People from rural areas are considerably more likely to travel by car than those from towns. The study found that mode of travel varies by age – older people are more likely to use public transport and 15% used other means of travel (such as taxis or transport schemes).

- National evidence suggests that over two-fifths (43%) of people have to travel for more than twenty minutes to reach their local hospital.

- Evidence on non-urgent patient transport contracts in Essex shows that the patterns of distances travelled varies quite considerably. Users of Acute Trusts in the more urban south of Essex tended to travel less far. For the Essex & Herts (combines Acute and community services), Basildon and Thurrock and Southend contracts between 75% and 81% of patients travelled 0-8 miles. In contrast, only around half of journeys for Essex Rivers Healthcare NHS Trust (47%) and Mid Essex Hospitals (52%) were 0-8 miles.

- The provision of public transport throughout the area appears to vary drastically. Whilst some individual services are fairly frequent and cost effective, other services are provided only once a day and are, in contrast, fairly expensive.

- There are clear benefits for those people living within the nearest town to the hospital, in relation to availability of transport. For patients in outlying areas, services can be extremely infrequent.

- There appears to be a concern about inaccessibility of public transport in certain areas, and also a fear of lack of safety.

**Siting and travel management**

- A number of local NHS bodies have clearly considered moving towards a more locally based model of service delivery, and this seemed particularly a concern of PCTs.

- Evidence suggests that NHS bodies do consider transport when deciding where to site new facilities. There does not seem to be any national or local guidance setting a process to be followed, and there seems to be local variation in who is responsible for such issues. It seems likely that in Acute Trusts which have 'Travel Plan Co-ordinators', this person would consider the accessibility of potential sites. PCTs do not seem to have prescribed processes in place for considering travel, although all those who replied said it is an issue that they would take into account. There is a risk that where no clear processes are in place, significant issues are missed.

- From the examples given, the land-use planning process seems to have provided the main framework for considering travel issues.

- Local evidence does not present a clear picture of how location choices have affected transport costs, and different bodies feel that the effects have been different.

- Transport costs for travelling to hospitals are borne by the NHS, private individuals or Local Authorities subsidising public and community transport services. Location may not be the most important driver of transport costs for the NHS. With most patients making their own way to treatment, the main factors behind NHS costs are suggested to be patients' clinical needs and the availability of suitable alternative transport (rather than the non-urgent patient transport service). Location might be a key factor in the cost to patients making their own way to hospital, but the NHS only pays for travel for a limited proportion of patients. Whether by private vehicle or public or community transport. There may also be costs to Local Authorities in terms of support for public and community transport, but these are difficult to quantify.

- Certain transport related issues must be considered in detail, using a specified process, when planning permission for major developments is sought. Issues that must be considered include the impact on the road network, car parking, provision for cyclists and pedestrians and public transport access. NHS bodies have followed this process on a number of occasions, and it seems to have encouraged the development of sustainable transport access to their sites.

- Significant changes to the system of transport planning are proposed in the Social Exclusion Unit report, including allocating local transport authorities a lead role in analysing and addressing accessibility problems in their area. The requirement for a systematic assessment of problems and the establishing of an action plan to address these will clearly help to reduce any inequalities of access to health facilities.

- Transport seems to be taken account of on a continuing basis in organisations with Travel Plans. Amongst other bodies, only Colchester PCT gave evidence of a system to ensure transport is considered through a formal arrangement.

- Car parking provision is clearly a serious concern for NHS bodies. Existing spaces in Acute hospitals are generally full and some have problems with illegal or dangerous parking. One witness expressed doubt that more spaces would solve the problem, as in her experience new spaces soon became filled up.

## 4 RECOMMENDATION

4.1 It is proposed that the Committee **RESOLVES**

To consider the report and make any comments it considers appropriate.

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**Background Papers:**

None.

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**Appendix**

## HEALTH SCRUTINY – NON-URGENT PATIENT TRANSPORT

## RECOMMENDATIONS

### Overall Conclusions

This is a complex topic. Any attempt to improve non-urgent patient transport to health facilities needs to take a rounded view of the following factors:

1. Most people travel to health facilities in cars or other private vehicles, and many of these people have problems in finding parking spaces. Whilst there are environmental arguments for encouraging people to use public transport, we consider that on the whole there is not enough car parking for the public (especially at acute hospitals). Our first response to this is that NHS bodies should make more effective use of existing car parking spaces: principally by shifting the balance of use from staff to the public and providing alternative ways, such as shuttle services, for staff to come to work; but also by providing adequate dropping-off and picking-up points. However, we also recognise that in some places, such as Southend, pressure on space is so great that improvement is unlikely without providing more parking spaces overall.

2. In addressing policy issues around car parking and the use of subsidised public transport to release existing parking spaces, NHS bodies will of course need to work closely with local authorities who are responsible for public transport policy. We have found that about 7% of patients already travel to health facilities by public transport, and whilst it may be possible to increase this we consider that it will be easier to encourage staff to use public transport through shift-change shuttle services and park and ride schemes. Another important balance for transport policy-makers to consider, however, is the one between public and community transport. Each service needs to be considered on its merits, but it is possible that where bus services are underused the subsidies supporting them might be better invested in community transport schemes. On the whole, these schemes can be much more tailored to the needs of the people who use them by providing, for example, a door-to-door service. Although such schemes are in principle membership clubs, people who are unable to travel by private vehicle or public transport can easily join the scheme and, where there is no entitlement to free travel, pay a small fee that helps to cover operating expenses.

3. Some people are currently entitled to free or at least subsidised travel. Where there is a medical need for non-urgent patient transport, this is currently paid for by Primary Care Trusts (partly through the acute sector NHS Trusts, historically) and provided mainly by the Essex Ambulance Service. We suspect that in practice a number of people are being carried for social as well as health reasons, ie, because

of the difficulties they would otherwise have in finding transport. We do not see this as necessarily being a problem. If the rule about only medical need were more strictly enforced, the level of missed appointments might increase. This would have costs in terms of both patients' health and the efficiency of the health service. Moreover, some people using the patient transport service for social reasons will have a genuine social need. However, we consider that the situation needs to be clarified by several steps:

a. In line with emerging Government policy, free non-urgent patient transport should be available for *both* medical *and* social need.

b. Free transport is currently provided by both social and health services. We believe that although it would be difficult to integrate these services totally from an operational viewpoint, efficiency gains could arise through shared use of vehicles and co-ordinated journey planning. These gains could be secured through joint commissioning arrangements between health and social services, in which at least some funding would be pooled allowing the scope for shared services to be determined through contracts or service level agreements with providers.

c. These joint commissioning arrangements would obviously require clarity about who is entitled to free transport. We do not propose any restrictions on the freedom of clinical decision about who needs free transport on medical grounds, although we note that in practice clinicians may not always be the ones taking these decisions and this may exacerbate a situation in which budgetary management is already difficult. Transport for social care is currently provided according to assessed need or generally under the Transport Act 2000 as socially necessary transport to enable people to access key local services. We suggest that commissioners of health and social care transport should agree criteria for free social need transport to health facilities based on the Social Exclusion Unit's report on transport. In addition to medical need, these would cover mobility difficulties (including the need for escorts), inadequate public transport (although, for reasons of equity with bus users who fall just below the threshold, this might entail subsidised rather than wholly free transport) and low incomes (see section 4.1F, below). The panel is unable to propose definite criteria without further analysis of cost implications and funding streams, and we must leave that task to executive agencies. However, we suggest that the criterion about inadequate public transport might be based on an assessment of the maximum time regarded as acceptable to travel a given distance. If a journey by public transport would exceed that time limit, the patient would be eligible for free carriage by the patient transport service. There might also be a rule that no journey should require more than two bus journeys in one direction. However defined, the criteria of need should be clear and consistently applied. Commissioners of free patient transport for social reasons will doubtless wish to ensure that funding provided hitherto through the Hospital Travel Costs Scheme comes to them.

d. Commissioners award most patient transport service contracts to the Essex Ambulance Service. We consider that the information required for performance monitoring needs to be made more consistent across these contracts, and that there

are issues (although these are currently being resolved) about whether the ambulance vehicle stock is as efficient as it could be. However, our main observation here is that the bulk of the non-urgent patients carried by the Ambulance Service travel not in ambulances but in volunteers' cars. In essence, this is a community transport service. With funding from NHS commissioners, other community transport services could also undertake some of this work. Integrating the voluntary car scheme with other community transport services in a locality might help to improve service coverage for both free and fee-paying health and social transport, and reduce unit costs across all schemes. Such a step would need to be negotiated by transport policy managers, health and social transport commissioners, the Essex Ambulance Service and community transport providers, and the integrated service could take one of several forms, from a single service through to more or less distinct services that simply help one another out at times of peak demand; but there seems no reason to keep the two types of community transport rigidly apart. The Ambulance Service's journey planning system might be helpful in managing an integrated service.

e. Whilst health and social care transport commissioners would globally fund the free non-urgent patient transport service, spending decisions are in effect taken at the point of booking of the service such as GP surgeries and hospitals. The fact that these decisions are not monitored is a weakness in the present arrangements. We consider that ICT should be used to monitor usage of the free service by booking points and that commissioners should in effect set a delegated budget, determined by an assessment of need, for each booking point. If a booking point then overspends, it would have to face the financial consequences itself. Consideration should be given to producing an ICT system for this purpose that covers free social care as well as health transport.

f. We believe there is a need for greater consistency across the Essex Strategic Health Authority area in performance information for the management of PTS contracts.

Finally, we consider that our proposals – particularly in respect of the integration of health and social care commissioning and of ambulance car and community transport services - should be piloted in the North East and South West sub-economies.

**Recommendations**

We relate our recommendations to the four objectives defined for this study.

**A To investigate the extent to which transport issues contribute to patients missing appointments**

The evidence we have found nationally and locally suggests that between 3% and 6% of patients miss appointments for transport reasons. However, we believe that the non-urgent patient transport service in practice carries people for social as well as medical reasons. If the requirement that passengers should be carried for

medical reasons only were strictly enforced, we suspect that the number of patients missing appointments might increase.

We therefore recommend that:

| **RECOMMENDATION A1** (see sections 4.1B, 4.1E and 4.1F) | **ACTION** |
|---|---|
| The patient transport service should give priority to patients needing transport for medical reasons. However, we believe that it is appropriate for the non-emergency ambulance service and community transport services to carry people free of charge for social as well as medical reasons, as long as the concept of "social need" is clearly defined. This should be in line with developing Government policy, which proposes eligibility based on medical needs, mobility difficulties, inadequate public transport and low income. The commissioners of these services should issue guidelines to ensure that needs are consistently assessed across the Essex and Thurrock areas. | Primary Care Trusts;<br>Social Services transport commissioners, consulting existing PTS providers as appropriate |

We have found that publicity for both the non-urgent patient transport service and the hospital travel cost scheme is limited. We therefore, recommend that:

| **RECOMMENDATION A2** (see section 4.1C) | **ACTION** |
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| Publicity about the existing schemes (and in due course their replacements) should be prominently displayed in all (and not just health) facilities used by people who may need transport assistance to meet health appointments. Publicity should be included in guidance leaflets provided by supportive organisations as well in poster form. This material should advise patients on how to make further enquiries. As a result of improved publicity there may be an increase in demand, and commissioners should consider how to respond to this. | Primary Care Trusts internally and in liaison with voluntary organisations;<br>NHS Trusts;<br>Partnership Trusts;<br>Social Services |

In future, part of transport planning should be the monitoring of "did not attend" rates due to transport reasons. We recommend:

| **RECOMMENDATION A3** (see section 4.1A) | **ACTION** |
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| In each sub-economy, NHS transport policy managers and patient transport commissioners should carry out a regular (though not necessarily frequent) sample survey with health care service providers of "did not attend" cases to establish, among other things, whether and how transport difficulties caused non-attendance. | Primary Care Trusts;<br>NHS Trusts;<br>Partnership Trusts |

**B To investigate avoidable inequality of access by transport to health services and to recommend a minimum acceptable standard of provision**

To minimise avoidable inequality of access, there is a need for an integrated approach across health services and local authorities to transport for patients, visitors and staff. We therefore recommend:

| **RECOMMENDATION B1** (see section 4.3D) | **ACTION** |
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| All NHS bodies should designate a transport policy manager, who might be a joint appointment across a sub-economy, to develop an integrated approach to all aspects of patient, staff and visitor transport to health facilities. These managers will need to work very closely with public transport authorities, patient transport commissioners and existing travel co-ordinators; and should be consulted on the transport aspects of all service variations and developments. Each NHS body should have a travel plan that is reviewed annually. | Essex Strategic Health Authority for sub-economy overview;<br>Primary Care Trusts;<br>NHS Trusts;<br>Partnership Trusts |

There are several types of inequality of access. One is geographical, in which remoteness of location may lead to long and difficult or expensive journeys for those without private vehicles. Given the varying patterns of population density across the County, there will clearly be some variation in time taken to travel to hospital or intermediate care facilities. However, we recommend that:

| **RECOMMENDATION B2** (see sections 4.2B, 4.2C and 4.2D) | **ACTION** |
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| NHS transport policy managers and health and social care transport commissioners across the ESHA area should agree and apply a table of maximum acceptable travel times for distances to be covered. In no case should any patient have to make a journey by public transport in one direction that involves more than one change between two public transport services. NHS transport policy managers should aim to ensure transport options are in place to achieve these standards, eg, providing new bus services through Urban or Rural Bus Challenge Funds, or sufficient free (or subsidised) transport through the patient transport service. This will often require working with and through local authority transport services. | Primary Care Trusts;<br>NHS Trusts;<br>Partnership Trusts;<br>Social Services;<br>Local authority transport policy services |

| **RECOMMENDATION B3** (see section 4.2C) | **ACTION** |
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| Transport policy managers should from time to time monitor the profile of journey distances and times to ensure that these standards are being met for all modes of transport. PTS commissioners could also use this information to adjust contracts or service level | As in B2 |

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| agreements as necessary. | |

Another type of inequality is where a person's own condition makes it harder for them to access health facilities with a reasonable level of mental or physical comfort. To address this, we recommend that:

| **RECOMMENDATION B4** (see sections 4.2A and 4.4B) | **ACTION** |
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| Arrangements should recognise the psychological and physical importance that escorts can have for patients. Every effort should be made to accommodate escorts in community transport where appropriate for a flat fee. | Primary Care Trusts; Social Services; Local authority transport policy services |

| **RECOMMENDATION B5** (see sections 4.4A and 4.4B) | **ACTION** |
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| Patient transport commissioners should set clear quality standards for volunteer drivers, including training required. | Primary Care Trusts |

| **RECOMMENDATION B6** (see section 4.3E) | **ACTION** |
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| NHS bodies should provide sufficient and satisfactory identified disabled parking and dropping off spaces at hospital and intermediate care facilities, in line with planning guidelines. | Primary Care Trusts; NHS Trusts; Partnership Trusts |

A further access issue is the availability of parking for those who travel to health facilities by private car. We believe that at present there is severe pressure on parking spaces, with on the whole more pressure on public than staff parking spaces. We recommend that:

| **RECOMMENDATION B7** (see section 4.3E) | **ACTION** |
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| Planning guidelines on parking spaces should be followed as much as possible in balancing staff and public use of car parking spaces. In general the policy should be to make more effective use of existing spaces than create new ones, but at Southend Hospital pressure is so great that an effective balance is unlikely to be possible without creating new spaces. For the longer term, with projected population growth, the adequacy of the planning guidelines themselves may need to be reconsidered. | Primary Care Trusts; NHS Trusts; Partnership Trusts; Local authority planning services |

| **RECOMMENDATION B8** (see section 4.3E) | **ACTION** |
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| Health agencies should seek to reduce levels of private car use at their facilities by adopting this as an objective and developing a package of measures to achieve it, set out in a Travel Plan. These measures should include (a) working with local authorities to support public and | Primary Care Trusts; NHS Trusts; Partnership Trusts; |

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| community transport, and (b) establishing a car-parking policy to discourage non-essential use. In order to reduce pressure on car-parking, consideration should be given by NHS bodies to:<br><br>• Re-designing services to reduce visits to the site<br>• Minimising the number of journeys that each patient makes [one stop shop]<br>• Encouraging use of sustainable transport<br>• Differentiating car parking spaces for different purposes | In liaison with local authority transport policy services |

| **RECOMMENDATION B9** (see section 4.3E) | **ACTION** |
|---|---|
| Health agencies should urgently create a shift from staff to patient use of NHS car parks. This should include parking charges for staff. Wherever possible, car parking revenues from those patients and staff who choose to drive a car could be used to finance alternative modes of transport include park and ride schemes and shuttle buses. | Primary Care Trusts;<br>NHS Trusts;<br>Partnership Trusts;<br>Local authority transport policy services |

| **RECOMMENDATION B10** (see section 4.3E) | **ACTION** |
|---|---|
| To relieve pressure on hospital car parks, consideration should be given to using measures such as (i) financial incentives for staff not to use their own cars, (ii) Park & Ride schemes for staff and public, and (iii) adequate provision of drop-off bays and pick-up points. | As in B9 |

**C To review the extent to which transport issues are featured within the criteria by which facility siting decisions are taken, and the extent to which these decisions impose costs on patients, relatives and other public bodies**

We found that whilst all NHS bodies give some attention to transport needs when deciding where to site health facilities, there is no consistency of approach. We therefore, recommend:

| **RECOMMENDATION C1** (see sections 4.3B and 4.3C) | **ACTION** |
|---|---|
| The DH or ESHA should formulate guidance on siting decisions which would require NHS bodies to consider the following:<br><br>• Adequacy of the road, rail and cycle path network leading to the site<br>• Availability of car parking spaces for staff and patients<br>• Availability and convenience of public transport | Essex Strategic Health Authority |

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| routes<br>• Impacts on non-urgent patient transport services and community transport<br>• Impact on emergency ambulance services | |

| **RECOMMENDATION C2** (see sections 4.3B and 4.3C) | **ACTION** |
|---|---|
| *NHS bodies should seek to locate facilities in places that minimise additional transport costs for patients. Health bodies should help to bear any additional costs of subsidising public and community transport in addition to support provided by local authorities. Services should be designed around patients' needs and located as close as possible to the people who need them – possibly in conjunction with other public services. We commend schemes for satellite and mobile clinics, and the development of more local service delivery.* | Primary Care Trusts;<br>NHS Trusts;<br>Partnership Trusts;<br>Essex Strategic Health Authority;<br>In liaison with local authority transport policy services |

| **RECOMMENDATION C3** (see section 4.3B) | **ACTION** |
|---|---|
| ESHA should facilitate the discussion of transport issues and integration of policy across the whole of its area as appropriate and certainly at sub-economy level. | Essex Strategic Health Authority |

## D To develop a list of priority areas or facilities in need of transport improvement action; to improve access to health facilities and levels of patient satisfaction and maximise efficient use of transport provision

The Panel decided at an early stage to focus on the South West and North East health sub-economies. The South West sub-economy is the natural concern of Thurrock Council, and for Essex County Council action on integrating transport provision following a Best Value review is being piloted in Colchester and Tendring. We propose that the following recommendations be piloted in those areas.

We recommend that:

| **RECOMMENDATION D1** (see section 4.4A) | **ACTION** |
|---|---|
| There should be integrated commissioning of free health and social care transport, planned across Essex and by health sub-economy. Primary Care Trusts should embrace their new responsibilities and work with local authorities in placing a coherent package of contracts and service level agreements. This ought to produce efficiency gains. Service standards sought by transport policy managers and commissioners should be consistent across the ESHA area as indicated in recommendation B2, which would also make performance monitoring | Primary Care Trusts;<br>Social Services transport commissioners;<br>Local authority transport policy services |

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| easier. The Essex Transport Co-ordination Centre could carry out the procurement process after discussion with and on behalf of commissioners. | |

| **RECOMMENDATION D2** (see section 4.4C) | **ACTION** |
|---|---|
| **The commissioning process should be used, in consultation with existing providers, to integrate the ambulance voluntary car service and community transport into a single transport scheme, covering health and social care needs, in each health sub-economy. This scheme would be jointly funded by NHS bodies and the local authorities.** | Primary Care Trusts; Social Services transport commissioners; Essex Ambulance Service; Local authority transport policy services |

| **RECOMMENDATION D3** (see section 4.4A) | **ACTION** |
|---|---|
| ICT systems should be set up to monitor the volume and geographical origin of requests for health and social care non-urgent transport from places such as GP's surgeries and hospitals. Commissioners should then set a reasonable spending limit on patient transport for each surgery or other transport arranger, which transport arrangers would exceed at cost to their other budgets. | Essex SHA; Primary Care Trusts; NHS Trusts; Partnership Trusts; In liaison with Social Services |

| **RECOMMENDATION D4** (see section 4.4B) | **ACTION** |
|---|---|
| Transport policy managers should consider a shift in funding from public to community transport where the latter is likely, through low usage of the public transport service, to prove a more efficient use of public money for non-urgent patient transport. | Local authority transport policy services |

| **RECOMMENDATION D5** (see section 4.4A) | **ACTION** |
|---|---|
| **Standards of performance information for the monitoring of patient transport contracts should be as consistent as possible across the Essex Strategic Health Authority area, specifying key information needed by commissioners to compare and judge the cost effectiveness of services. These standards should cover the time patients have to spend waiting for their transport to arrive to take them to hospital and home again.** | Primary Care Trusts, in liaison with Social Services transport commissioners; Consulting the Essex Ambulance Service and other PTS providers as appropriate. |