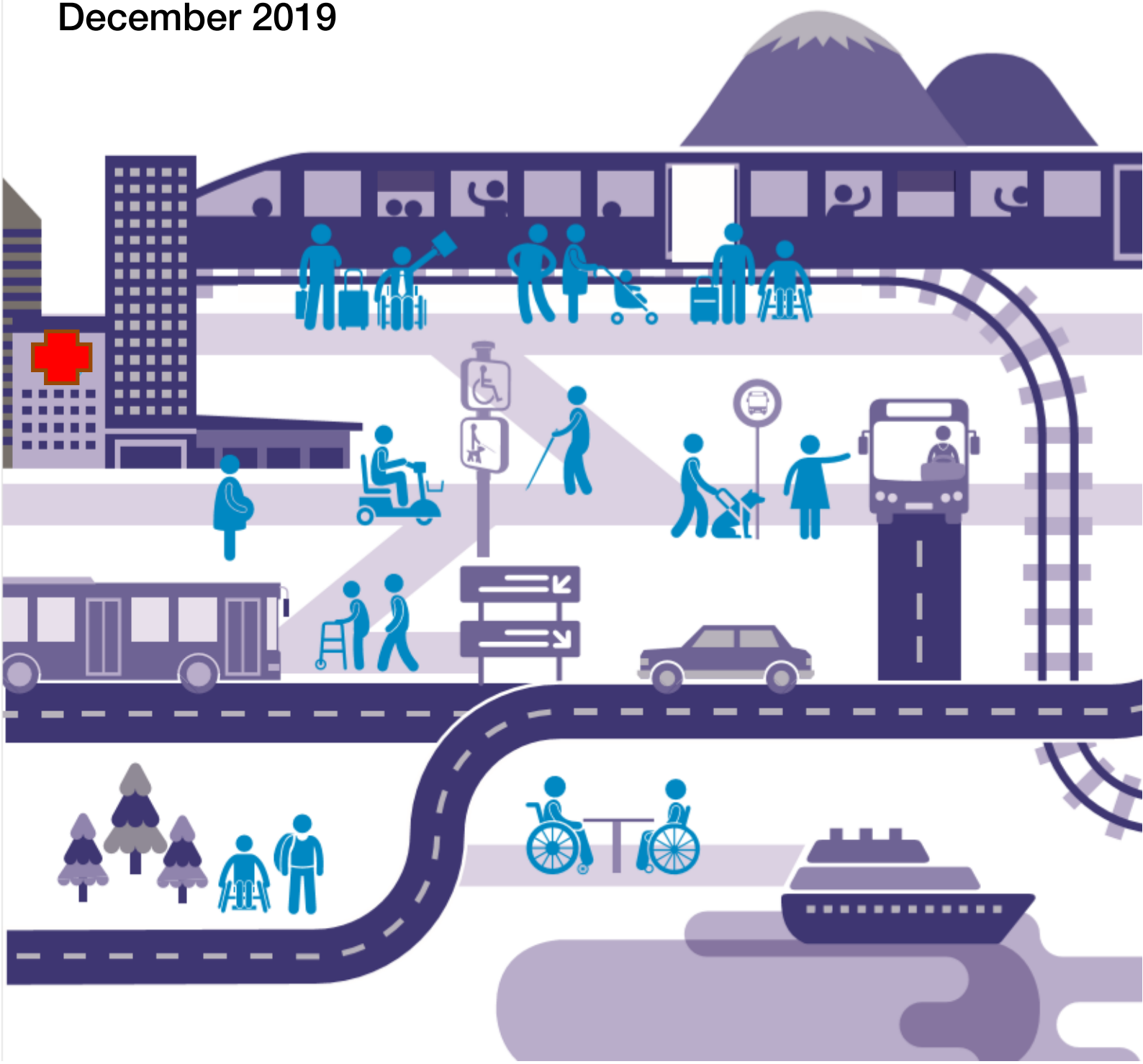
MACS
Advising Scottish Ministers on Accessible Travel

Mobility and Access Committee for Scotland

Report: Transport to Health and Social Care

December 2019



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1. MACS National Convener's Introduction

I would like to take this opportunity to formally thank everyone who has been involved in our work over the past nine months to help us gain a better understanding of what works and what poses barriers for individuals accessing health and social care services.

This is the start of MACS' journey in this area and our findings stand us in good stead to have further dialogue, give advice to Scottish Ministers and to ensure the voices of disabled people and older people in Scotland are heard. It is our intention to use these findings to advocate for the changes needed to remove some of the barriers disabled people and older people face when accessing health and social care facilities. These are long standing issues.

MACS has reached out to several organisations and many individuals and asked them to share their experiences about the challenges they face when booking and getting to and from medical appointments.

In particular, we would like to thank Emma Scott, Disability Equality Scotland; Emer Murphy and Rachael Murphy; Community Transport Association in Scotland; the members of Badenoch and Strathspey Access Panel; Lochaber Access Panel and Voluntary Action Lochaber.

I would also like to thank my MACS Transport to Health and Social Care working sub-group, who have worked tirelessly over the last nine months, committing a great deal of their personal time to progress an agenda that they are passionate about and committed to advocating the need for change, the need to do things differently, and to allow the voices of those who use the services to be at the centre of designing these services around their needs.

Only when we take this approach will we have a chance of getting service design right and fit for purpose. This co-production approach fits with the ethos of "nothing about us without us".

Our "phase one" work has made recommendations based on all our work over the last nine months. Some of these recommendations are proposals to revisit past initiatives that had to stop due to sustainability of funding and some may be seen as ambitious and transformational.

We feel that this level of change is needed to start to make 'in roads' on this long-standing issue.

This change is needed to assist with delivering on the priorities of the imminent revised National Transport Strategy, the Fairer Scotland for Disabled People ambitions, and to ensure that those who need assistance to get to their health and social care appointments are not left to struggle and navigate what can be complex and stressful arrangements, before even reaching the medical facility for their treatment.

During our work we reflected on the 2011 Audit Scotland Report "Transport for Health and Social Care"[1] and we were disappointed to find that not much has changed since this report and that many of our recommendations replicated those made eight years ago by Audit Scotland.

In producing this report, of our phase one work, we ask that those who can, take away these messages, and we have no doubt that the personal testaments around the impact the current practices and barriers have on people's lives will energise the agenda in the knowledge that we need to make things better.

For those who can, please consider these recommendations and work towards doing your bit, even if it's just **one thing** that you focus on.

If everyone who reads this report, and those who have been involved to date, take away **one thing** to advocate and progress, we can start the change process and re-energise conversations.

Yours sincerely,

Linda Bamford
National Convener
Mobility and Access Committee for Scotland (MACS)

[1] Audit Scotland Report

2. Executive Summary

During 2019 the Mobility and Access Committee for Scotland (MACS) undertook research to explore the transport barriers faced by disabled people and older people when accessing health and social care appointment and facilities. This work was undertaken to gather insights, find out about initiatives that worked well, and gain a better understanding of the issues and barriers facing disabled people and older people when accessing these essential services.

This research and evidence gathering involved a Transport to Health and Social Care roundtable discussion, hosted by MACS with assistance from Transport Scotland, and independently facilitated by the Scottish Government. This event brought together around 40 stakeholders, including individual disabled people, Disabled People's Organisations (DPOs), Community Transport Association (CTA), Transport Scotland (TS), Regional Transport Partnerships (RTPs), representatives from NHS Boards, Access Panels and Local Authorities (LAs) (detailed within **Section 5** and **Annex A**).

We also undertook an extensive evidence gathering exercise capturing the voices of over 1000 disabled people (**Section 4**).

This **MACS Report: Transport to Health and Social Care** is a summary of the findings of this work, including **9 key issues** clustered around five themes (**Section 6**), and **27 recommendations** to Scottish Ministers and others (**Section 8**).

Some of these key findings are:

- From MACS findings during research and evidence gathering, it is apparent that little or no progress has been made on Transport to Health and Social Care since the Audit Scotland Report in 2011. Indeed, many of MACS recommendations from this phase one work reflect those previously made by Audit Scotland.
- There is growing concerns amongst disabled people and older people in relation to the transport barriers accessing Health and Social Care appointments and facilities (this is evidenced in the second Disability Equality Scotland (DES) Poll run in August 2019, which attracted a much higher return rate than the initial poll, 849 people responded with 98 per cent of those responding stating that they faced transport barriers accessing health and social care appointments.
- There needs to be better joined up planning and working between the NHS, Local Authorities and Scottish Ambulance Service, Regional Transport Partnerships and Community Transport providers should also be central to these discussions.
- There is an absence of, or very limited/poor methods of, signposting to alternative transport organisations, with the onus left with patients to navigate complex arrangements.
- The Scottish Ambulance Service (SAS) doesn't have the capacity to meet demand and is filling the gap caused by poor public transport options.
- There is a gap in public transport, due to a lack of options (including accessible and affordable options) for some, especially in rural areas, and the SAS does not have the capacity to meet this demand.
- SAS' changes to the Patient Needs Assessment (PNA) application, changes to the escort eligibility criteria, daily demand capping and the loss of the SAS voluntary car service, have significantly reduced the number of journeys/bookings the SAS can accept. People are struggling to find suitable and affordable alternatives.

- Bus timetabling and routes don't meet people's needs and fail to connect communities to health and social care facilities.
- There are issues with the first and last part of the public transport journey, i.e. from the house to the bus stop and from the bus stop to hospital/medical facility, as well as the distance between departments within some hospital campuses/sites (i.e. the Queen Elizabeth University Hospital, Royal Infirmary Edinburgh, Glasgow Royal Infirmary).
- NHS websites tended to signpost to Traveline Scotland or Google maps, neither of which are particularly good for identifying accessible transport options needed for planning a journey. The accessibility of these websites is poor for people with visual impairments and those using screen readers.
- The planning and design of buses, bus routes, bus stops, information points, and public toilets are not geared towards disabled people and older people using public transport to get to hospital and other essential services.
- Disabled people and older people are not given enough influence over how transport to health and social care facilities works to tackle any difficulties they experience.
- The CTA's assistance with transport to health and social care appointments is not acknowledged and recognised and they are having to refuse some requests for transport to health and social care appointments from people within their communities, who have little or no alternatives.
- The reimbursement rate for CTA volunteer drivers is unaffordable to many, particularly for people in rural areas where distances are longer, as costs are based per mile.
- Many disabled people and older people cannot travel independently by bus (due to mobility, confidence, or medical condition).
- Coaches on registered bus routes have affected people's choices and eliminated bus travel as an option to get to medical appointments due to accessibility issues/barriers linked to the design of the coach.
- Wheelchair spaces can't be booked on buses. Therefore wheelchair users have no guarantee of being able to use bus services.
- For many people on low income the "Help with Health Costs Scheme" and NHS reimbursement schemes don't work because the schemes do not meet their needs or take account of their individual circumstances.
- NHS Reimbursement schemes are complicated and over bureaucratic.
- The National Entitlement Card (NEC) Scheme is not flexible enough and the 'plus a companion' facility could be widened.
- The group agreed that many people who have a National Entitlement Card (bus pass) cannot use it, as there are poor bus services (or no accessible buses) in their areas as many of these routes are not commercially viable and services have been withdrawn.
- Hospital parking costs (even for Blue Badge holders) is unaffordable.

3. Background: MACS

MACS is an advisory non-departmental public body. The Committee has 14 members appointed by the Cabinet Secretary for Transport, Infrastructure and Connectivity in the Scottish Government. The overarching remit of the Committee is:

- To give Scottish Ministers advice on aspects of policy, legislation and practice affecting the travel needs of disabled people.
- To take account of the broad views and lived experiences of disabled people when giving advice.
- To encourage awareness amongst disabled people in Scotland of developments which affects their mobility, choices and opportunities.
- To work closely with the Scottish Government and ensure our work programme complements the work being undertaken by the Disabled Persons Transport Advisory Committee (DPTAC), the Equality and Human Rights Commission and other organisations, voluntary and statutory.
- To promote the travel needs of disabled people with designers including transport planners and operators so that these are fully taken into account in the development of vehicles and infrastructure and delivery of services.
- To monitor and evaluate the effectiveness of our work against the above aims and objectives in improving travel opportunities for disabled people in Scotland.

To deliver on this remit MACS works across Ministerial portfolios and has recently been more engaged with, not only the Transport portfolio, but also the Health and Older People and Equalities portfolios.

During MACS external engagements, as part of our remit to seek the views and lived experiences of disabled people, we are frequently being made aware of issues and barriers faced by disabled people and older people when accessing health and social care, using either transport provided by SAS, Hospitals, Local Authorities and/or public transport in general.

These experiences cited problems not only with the **A**vailability, **A**ccessibility and Affordability of transport (the triple **A** check) but also with the availability and accessibility of the information provided about services, the eligibility criteria for transport (particularly with SAS) and/or the booking processes.

Due to the above issues, MACS agreed to engage further on Transport to Health and Social Care.

4. Evidence Gathering

To complement and prepare for the roundtable discussion, MACS provided a briefing paper to all participants. This summarised the findings of the engagement and research work undertaken by them in advance. This included extensive survey work, desk based research, and attending external meetings and workshops, as discussed below.

In November 2018 Disability Equality Scotland (DES) undertook a weekly poll of their membership on behalf of MACS, themed around Transport to Health and Social Care. 28 returns were received. Some respondents were extremely emotive in the description of the impact the issues accessing transport to health were having on them and on many disabled and older people in Scotland. This survey work formed a prelude to a far bigger exercise to gather the views of disabled people carried out by DES, which is also discussed below.

In January 2019 MACS raised some of these issues with the Minister for Public Health, Sport and Wellbeing, Mr Joe Fitzpatrick, who acknowledged them, agreed to give them focus, and asked MACS to gain further insights to update him.

MACS asked DES to re-run this poll in August 2019 and found a similar position with no change in terms of the barriers.

However, this follow up poll attracted a very much higher return rate of **849** responses with **98 per cent** of respondents confirming they had encountered problems with either booking or getting transport to healthcare facilities. This poll again captured many emotive case studies describing the impact of not being able to book or access transport to attend medical and social care appointments.

In response to the above issues MACS convened a working sub-group to take a deeper dive into Transport to Health and Social Care, and agreed to collate some evidence prior to hosting a roundtable event with key stakeholders to discuss their findings.

CTA, which is the national charity that represents and supports providers of community transport, also carried out survey for MACS to gather evidence.

The CTA represents over 130 charitable organisations that offer transport in Scotland.

For those who cannot access public or private transport, community transport may be the only way they are able to attend health appointments. The research investigated barriers and challenges associated with transport to health journeys administered by community transport operators in Scotland. Some of the key research findings are shown below.

Evidence Gathering Box 1: **CTA research findings**

The survey found that:

- 79% of community transport organisations responding undertook transport to health
- 26% of community transport organisations responding received funding specifically to undertake transport to health
- 74% of community transport organisations responding, who receive funding to undertake transport to health, do not consider the funding to be adequate
- 61% of community transport organisations responding said they had received requests for transport to health appointments that they have had to refuse
- 18% of community transport organisations responding had received a request from their local authority to administer transport to health journeys
- 32% of community transport organisations responding had received a request from NHS Boards to administer transport to health journeys
- 68% of community transport organisations responding had received a request from patients themselves to administer transport to health journeys
- 61% of community transport organisations responding had transport to health schemes run by volunteer drivers

Resource barriers mentioned by community transport operators included administration, volunteers, lack of existing data and research and marketing approach. Systematic inconsistencies identified included accountability, management and administration, and funding.

The researcher made the following policy recommendations:

- Notable discrepancies exist in the way community transport operators are funded and commissioned to administer transport to health journeys. This tends to be a very grey area often disadvantaging community transport operators. The researcher recommends a standardised system/framework that employs a level of flexibility, thus can be applied on a regional or case by case basis. Purposefully, this will offer a level of protection to community transport operators.
- The researcher recommends a synergised approach to management and administration of transport to health journeys. The findings suggest that community transport operators are under resourced, which is evident by the refusal rate of transport to health requests received by organisations. A level of support is required from NHS/SAS to effectively and efficiently administer this service.
- Many community transport operators do not specifically label their transport to health activity, despite the fact they are executing multiple journeys every day, week and year. This results in inadequate recognition from Health Boards, thus impending their ability to be funded appropriately. The researcher recommends that community transport operators adapt a ‘marketing strategy’ that highlights the amazing work that they do. Effectively, this is a marketing ploy to gain the recognition they deserve.

MACS also undertook a review of available information about transport to health on NHS websites.

Evidence Gathering Box 2: **Findings of NHS website checks**

Key findings:

1. Overall the NHS websites tended to signpost to Traveline Scotland or Google maps, neither of which are particularly good for identifying accessible transport options needed for planning a journey. This includes failing to respond to the needs of people using screen readers to understand what the public transport options are. Where signposting to alternative transport providers was included, this gave no information other than the name of the organisation. For those needing to plan their journey around their accessibility needs, Traveline cannot currently accommodate this request in the journey planning function.

2. The overall accessibility of the maps provided or links to Google maps was poor and would not make planning a journey easy. The lack of phone numbers makes it even harder for those not digitally connected to attempt to use this information to plan a journey.

3. The information on travel reimbursement was inconsistent and excluded the reimbursement towards the costs for private taxis, even though in some areas (rural) this was the only option available. Many NHS Board and hospital websites gave no information at all on travel options or reimbursement of costs for those on low incomes. Note: The lack of information on reimbursement for taxi journeys may be because currently the NHS doesn't appear to reimburse taxi fares, even though this may be the only way some people can reach their appointments.

4. Individual NHS Boards have websites for each of their hospitals but the information they publish on these websites for their facilities is not consistent.

5. Most sites don't provide information on the bus stop location, its distance from the main entrance or the road/pavement gradient to make it easier for patients to prepare and plan the journey.

6. MACS welcomes the NHS Greater Glasgow and Clyde (Stobhill Hospital's) initiative, which states that concessionary cardholders can show their hospital appointment cards to get concessionary travel before 9 am.

7. MACS found every site to be different and that it was not always apparent where information on travel to hospital or reimbursement of costs could be found. MACS suggests that it would be better if headings and information could be standardised on NHS websites and the information on travel cost reimbursement made more prominent.

This systematic review work also identified issues around **a**vailability, **a**ccessibility and **a**ffordability. Some examples are provided below:

Availability:

- There needs to be better joined up planning and working between the NHS, Local Authorities and SAS.
- There is an absence of, or very limited/poor methods of, signposting to alternative transport organisations, with the onus left to patients to navigate complex arrangements.
- NHS websites tended to signpost to Traveline Scotland or Google maps, neither of which are particularly good for identifying accessible transport options needed for planning a journey. These websites also have poor accessibility features for people with visual impairments.
- The SAS doesn't have the capacity to meet demand and is filling the gap caused by poor public transport options.
- There is a gap in public transport due to a lack of options (including accessible and affordable options) for some, mainly due to rurality, and the SAS does not have the capacity to meet this demand.
- The SAS changes resulting in stricter application of the Patient Needs Assessment (PNA), changes to the escort eligibility criteria, daily demand capping and the loss of the SAS voluntary car service, has significantly reduced the number of journeys/bookings the SAS accept. People are struggling to find suitable and affordable alternatives.
- Bus timetabling and routes don't meet people's needs and fail to connect communities to health and social care facilities.
- The CTA's assistance with transport to health and social care appointments is unrecognised and they are having to refuse some requests for transport to health and social care appointments from people within their communities, who have little or no alternatives.

Accessibility:

- Many disabled people and older people cannot travel independently by bus (due to mobility, confidence, or medical condition).
- The planning and design of buses, bus routes, stops, information points, and public toilets are not geared towards disabled people and older people getting to hospital and other essential services.
- Coaches on registered bus routes have affected people's choices and eliminated bus travel as an option to get to medical appointments due to the inaccessible design of the coach.
- Wheelchair spaces can't be booked on buses therefore wheelchair users have no guarantee of being able to use bus services.

Affordability:

- For many people on low incomes the Help with Health Costs scheme and NHS reimbursement schemes are complicated and forms difficult to complete.
- The National Entitlement Card Scheme is not flexible enough and the ‘plus a companion’ facility could be widened.
- Many people who have a National Entitlement Card (bus pass) cannot use their bus pass, as there are poor bus services (or no accessible buses) in their areas as many of these routes are not commercially viable and services have been withdrawn.
- Hospital parking costs (even for Blue Badge holders) are unaffordable.
- The reimbursement rate for CTA Volunteer drivers is unaffordable, particularly in rural areas where distances are longer and costs are based per mile.
- Special permission has to be sought for use of taxis or for payment of a companion's travel costs.
- Where a hospital appointment requires an overnight stay (more prevalent for patients from rural areas and the Islands) the cost to the individual for accommodation is often unaffordable.
- For Islanders who require frequent trips to the mainland for medical appointments, the ferry travel is often unaffordable and current discount and voucher schemes don’t eliminate the financial burden of these costs.

On top of regular engagement with disabled people, MACS undertook a variety of other engagement work on this topic in advance of the roundtable discussion, including the following:

Engagement with Audit Scotland (AS):

In 2011 AS published a report on Transport to Health and Social Care[2] with recommendations on how to improve the whole health and social care system and make it work efficiently. Unfortunately the progress from these recommendations are either minimal or non-existent.

The key messages from the 2011 report being:

> Transport services for health and social care were fragmented and there was a lack of leadership, ownership and monitoring of the services provided. The Scottish Government, Regional Transport Partnerships, councils, NHS boards and the ambulance service were not working together effectively to deliver transport for health and social care or making best use of available resources.
>
> From the limited information available at the time it was identified that over £93 million was spent in 2009/10 on providing transport to health and social care services. This was a considerable underestimate as data on costs, activity and quality was poor. As such, the public sector would find it difficult to make efficient and effective use of available resources without this basic information.
>
> Joint working across the public sector and with voluntary and private providers was crucial for the successful and sustainable development of transport for health and social care. Improved joint planning could lead to more efficient services. There was scope to save money by better planning and management of transport for health and social care without affecting quality. Pilot projects showed scope for efficiencies but these lessons have not been applied across Scotland.
>
> Reducing or removing funding from transport services had a significant impact on people on low incomes, older people and people with ongoing health and social care needs. But the potential effect of changes to services was not often assessed or monitored and alternative provision was not put in place.
>
> The public sector needed better information on individual needs and on the quality of the transport services they provide.

In 2011 Audit Scotland made key recommendations, including that the Scottish Government and partners should:

- Work together to clarify responsibilities for planning and delivering transport for health and social care and how these link together.
- Partners (councils, NHS boards, Regional Transport Partnerships and the ambulance service) should: collect routine and accurate data on the activity, cost (including unit costs) and quality of services they provide and routinely benchmark performance and costs to ensure resources are used efficiently.
- Assess the impact of proposed service changes on users and other providers of transport.

[2] AS report on Transport to Health and Social Care

- Ensure that staff have up-to-date information about all transport options in their area and provide better information to the public about available transport options, eligibility criteria and charges.
- Integrate or share services where this represents more efficient use of resources and better services for users, including considering an integrated scheduling system.
- Ensure that transport for health and social care services is based on an assessment of need and that it is regularly monitored and evaluated to ensure value for money.
- Use the AS checklist detailed in **Appendix 3** of the full report to help improve planning, delivery and impact of transport for health and social care through a joined-up, consistent approach.

Engagement with Grampian Health and Transport Action Plan:

To network and discuss issues concerning travelling with confidence. This included attending workshops with service providers and service users to openly discuss the transport barriers people faced getting to and from hospital appointments, including their lack of confidence using a public transport system that was not fully accessible and unreliable.

Meetings with Access Panels:

This including the Convener meeting with Badenoch and Strathspey Access Panel (BaSAP), Lochaber Access Panel (LAP) and Voluntary Action Lochaber (VAL) to discuss local work undertaken around Transport to Health and Social Care. The Access Panels and voluntary Action Lochaber shared their experiences in both running a community transport scheme that was taking people for medical appointments and local social care facilities (BaSAP), and assisting people to get transport to their appointments by signposting to other organisations of being the conduit between the individual and the SAS to secure transport on medical grounds (LAP and VAL).

Engagement with the Scottish Ambulance Service:

MACS attended the SAS consultation event on patient transport service vehicle design. They also invited the SAS, Head of Patient Transport Service to a MACS Main Committee meeting.

The Convener attended the Disability Equality Scotland (DES) and SAS workshop in November 2019 to obtain an update from the SAS on their operating model for scheduled care services and also to listen to the voices of those in attendance (disabled people) and hear first hand of their experiences trying to book and use transport provided by the SAS.

Engagement with the Equality and Human Rights Commission (EHRC):

Engagement and liaison with the EHRC falls within MACS overarching remit. As part of their work on Transport to Health and Social Care, MACS continues to link with the EHRC around Strategic Goal 1 - Priority Aim 2 of their strategy for 2019-22[3].

Engagement with the Scottish Poverty and Inequality Commission:

MACS continued to link with the Poverty and Inequality Commission's work around Transport and Poverty in Scotland[4]. This links with MACS' triple **A** check for transport i.e. that it is **A**ccessible, **A**vailable and **A**ffordable.

Engagement with the draft National Transport Strategy (NTS2)[5] and the Strategic Transport Projects Review (STPT2)[6]:

MACS remained connected to the above emerging strategies and policies at a strategic level, messaging on the need for a transport system that reduced inequality and provided fair, affordable and easy access for all, regardless of ability, where people lived (urban, rural, Islands) or their level of income.

This messaging took opportunities to identify the current transport barriers accessing health and social care and asked for this to be an integral part of transport strategies and policies moving forward.

Engagement with Transport Scotland's Accessibility Team

Through the Accessible Travel Framework Steering Group meetings and through regular update meetings, MACS advocated for Transport to Health and Social Care to be considered as a priority area for Transport Scotland's Accessibility Team moving forward and for this to be planned for and incorporated within the Annual Delivery Plans from 2020 onwards.

[3] EHRC Strategic Plan
[4] Poverty and Inequality Commission report on Transport and Poverty in Scotland
[5] The National Transport Strategy
[6] The Strategic Transport Projects Review

MACS has also undertaken a significant amount of desk-based research such as collating comments on transport to health submitted via the "Care Opinion" website[7] and examining relevant reports such as that produced by the Department for Transport on its Total Transport pilot initiatives[8].

Evidence Gathering Box 3: **Total Transport**

Total Transport is about finding ways of commissioning public sector funded transport so that passengers get a better service with less duplication of resources. This can include services like non-emergency patient transport, adult social care transport and home to school transport.

These are all similar, provided in the same geographical area and often carrying the same passengers at different times. Department for Transport (DfT) allocated £7.6m to 37 separate schemes run by 36 local authorities in England to pilot Total Transport solutions in their areas. These pilots were focussed on rural areas. A number of key themes emerged from the pilots:

- Tackling integration involves a degree of local knowledge;
- While some approaches may be transferable, there is no easy 'one size fits all' solution;
- Constructive local engagement is important and it can take time to find the right person to engage with in each organisation;
- There is more to do to unlock the opportunities for integration between transport provision in the health sector and local authorities;
- Financial savings are difficult to assess as many participants did not have access to reliable 'before' data, although some savings do appear to have been achieved;
- While the actual savings achieved so far may be considered relatively low, the process has led to improved services in some areas at similar cost, and uncovered potential savings and benefits for the longer term;
- The benefits of Total Transport are a mix of short, medium and long term. Some of the bigger savings will take time to be delivered and benefits from larger scale changes can take time to bed down;
- Some of the delivery models proposed do not easily fit the existing legal framework of bus services, taxis and private hire vehicles and have required careful development to allow them to operate;
- The process of bidding for funding acted as a stimulus to think about provision in a different way and gave the successful local authorities the resource to look at new ways of working that they would not have had the space to do under 'business as usual'.

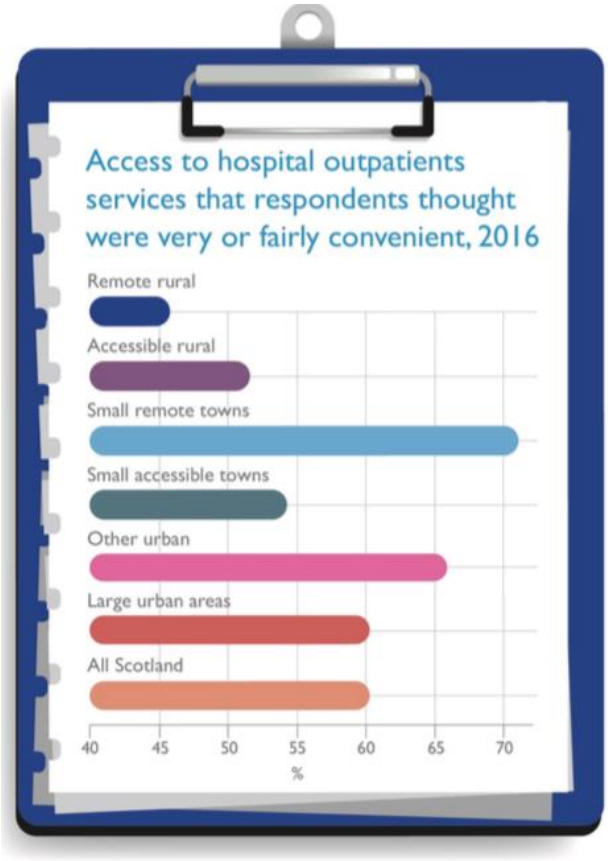
All of this work, taken together with the record of the Roundtable at **Annex A**, informs the recommendations of MACS to Ministers and other organisations on this topic (**Section 8**).

[7] The Care Opinion website
[8] UK Department for Transport's Total Transport Feasibility Report and Pilot Review

5. Roundtable Discussion

Through direct lived experience and engagement with disabled people and DPOs, MACS is frequently made aware of issues and barriers faced by disabled people when accessing healthcare using either specialist patient transport, public transport, or other means.

This is borne out by statistical evidence. In Scotland there is evidence from Transport and Travel in Scotland 2016 to show that only 60 per cent of people (disabled and non-disabled) consider access to hospital outpatient services to be very or fairly convenient. This drops to 46 per cent in remote rural areas.



These percentages do not fully reflect the problems faced by disabled people and older people. It is likely that for these groups the percentages would be significantly higher given:

- The examples and case studies reflected within the Disability Equality Scotland poll with 849 respondents (**Aug 2019 Poll Summary Report**);
- The fact that these groups are more reliant on assistance getting to hospital because of the known barriers with specialist patient transport and limited public transport options (current service provision failing the triple **A** check: **A**vailable, **A**ccessible and **A**ffordable);
- That disabled people and older people are more likely to need to attend medical appointments more frequently due to their underlying medical conditions as well as the needs of an ageing population;

- The prediction within the Programme for Government (PfG) 2019/20[9] relating to reducing waiting times is "this year's investment will support more procedures such as cataract removal and hip and knee replacements, **as well as increasing the number of outpatient and diagnostic appointments".** It's likely that to achieve this it will, in-turn, increase the need for accessible transport options, and;

- That people on low incomes are more likely to suffer ill health.

As a result of these findings, combined with what people were telling us, a Transport to Health and Social Care Roundtable was convened in November 2019 by MACS to discuss the issues further.

This roundtable discussion had the following purpose:

- To discuss the research and evidence gathering key findings, acknowledging the impact of these issues on disabled people, older people and people on low or restricted incomes;

- To identify and recommend potential solutions, including potential opportunities for collaborative working and coproduction to improve booking and securing transport to healthcare facilities;

- To ensure the broad views and lived experiences of disabled people were heard in relation to the barriers they face booking, accessing and affording transport to medical appointments;

- To allow for discussions that will identify and share good and best practice;

- To identify improvements required in the information provided by territorial NHS Boards and National Boards (SAS and the National Waiting Time Centre) to assist with public transport journey planning and signposting to alternative transport providers;

- To discuss issues raised around the SAS booking process and share suggestions (made by disabled people) aimed at making the booking process easier and more consistent;

- To identify where links to transport providers and journey planning information (including to the Accessible Travel Hub hosted by Disability Equality Scotland) could be improved to assist with the booking process;

- To set the scene for the development day (hosted by MACS) in March 2020, themed around improving transport to health care facilities;

- To agree further actions required moving forward including recommendations and advice MACS can offer to Scottish Ministers, transport and service providers and key stakeholders, and;

- To be clear that stakeholders understand that MACS is not an implementing authority and our remit is to understand the current position, including barriers, ensure the broad views and lived experiences of disabled people are heard, give advice and make recommendations that could deliver improvements if followed.

[9] Scottish Government's Programme for Government 2019-20

Participants at the event included individual disabled people bringing their direct lived experience of the issues, and representatives of a number of the organisations listed below. MACS identified these attendees as being key stakeholders in any work to improve Transport to Health and Social Care. From those invited, over 40 participants took part.

Note: A full record of the Transport to Health Roundtable, including the list of attendees, can be found within **Annex A** of this report.

MACS sought to get as wide a section of organisations involved in Health and Social Care transport planning and service provision and those responsible for leading on Equality and Inclusion within the NHS to the roundtable.

As well as bringing a wealth of knowledge and experience to the table it was thought that those invited had the capacity to influence change.

MACS' pre-roundtable briefing paper gave information on their findings during the research and evidence gathering stage, and signposted to other useful research and documents that MACS had drawn on and that would be useful background reading for attendees. The most recent survey results and reports from DES and the CTA were also distributed to all attendees prior to the event.

The agenda for the roundtable was constructed to ensure the day allowed time to confirm the current barriers, with the majority of the time being allocated to open discussion on the key findings.

The afternoon session was utilised to work in groups to seek solutions to the current transport barriers to accessing Health and Social Care appointments and facilities.

6. Key Issues

Through the discussion and evidence gathering exercises, the following key issues were identified:

Theme 1 - Accessibility - **Public transport barriers:**

- There is a lack of knowledge and awareness of what is available and by which organisation/transport provider i.e. hospital transport, local authority, community transport, ambulance service, voluntary drivers and charities/community initiatives.

- There is growing concern amongst disabled and older people in relation to the transport barriers accessing Health and Social Care facilities and how these are planned without meaningful engagement with service users.

- Disabled and older people are not given enough influence over how transport to hospitals and medical facilities works. This misses out on using their direct lived experience to design services that meet their needs and shows a lack of meaningful engagement in line with “nothing about us without us”.

- The replacement of buses with coaches has presented an additional barrier accessing Health and Social Care appointments and facilities for people with reduced mobility, due to the inaccessible design of some coaches.

- The planning and design of buses, bus routes, bus stops, information points, and public toilets are not geared towards disabled people and older people getting to hospital and other essential services.

- The first and last mile of the journeys is the most problematic (i.e. from door to bus stop and bus stop to medical facility).

- Many disabled and older people cannot travel independently by bus (due to mobility, confidence, medical condition). This links to limited affordable options to travel with a carer or companion.

- Bus timetabling and routes don’t meet people’s needs and fail to connect communities to health and social care facilities. This includes frequency of bus services, operating hours and network coverage (more problematic in rural areas)

Theme 2 - Booking information - Formats and signposting to alternative transport providers (what’s currently out there):

- Individual NHS Boards have websites for each of their hospitals but the information they publish on these websites for their facilities is not consistent and in most cases not in accessible formats.

- NHS websites tended to sign post to Traveline Scotland or Google maps, neither of which are particularly good for identifying accessible transport options needed for planning a journey. Accessibility of these websites is also poor.

- Most sites don't provide information on the bus stop location, its distance from the main entrance or the road/pavement gradient to make it easier for patients to prepare and plan the journey. This adds to the problem with the first and last mile.

- Booking processes are complicated and time consuming. They are heavily reliant on phone calling and queuing with no options for on-line booking.

- There is an absence of or very limited/poor methods of signposting to alternative transport organisations, with the onus left with patients to navigate complex arrangements.

Theme 3 - Availability - Scottish Ambulance Service booking procedures and impact of limited resources:

- The SAS doesn't have the capacity to meet demand for transport and is filling the gap caused by inadequate, inaccessible and unaffordable public transport.

- Changes made by the SAS to the Patient Needs Assessments, escort eligibility criteria, daily quotas/capping for journey numbers and the loss of the volunteer car service has significantly reduced the number of journeys the ambulance service undertakes and individuals and other services are being hit with the knock on effects (i.e. the CTA).

- There was little evidence of the SAS meaningfully engaging with users of the service during transformation and redesign and an absence of evidence in relation to conducting Equality Impact Assessments for any redesign or service changes on line with the Public Sector Equality Duty.

Theme 4 - Community Transport - Assistance and voluntary transport groups:

- There is an absence of, or very limited/poor methods of, signposting to alternative organisations with the onus left with patients. This links with there being no apparent resource sharing. For example, most people booking community transport are doing so themselves, normally through local knowledge, which could be addressed by involving Community Transport Operators in the Transport Planning (i.e. Health Board, Local Authority and SASall around the table).

- The local Community Transport Schemes are filling the gap in transport to health and social care. This demand is outstripping resources (financial and assets) resulting in many requests for transport being refused.

- The CTA's assistance with transport to health and social care appointments is unrecognised and they are having to refuse some requests for transport to health and social care appointments from people within their communities, who have little or no alternatives.

- The reimbursement rate for CTA Volunteer drivers is unaffordable to many, particularly in people in rural areas where distances are longer and costs based per mile.

Theme 5 - Affordability - NHS Reimbursement Schemes and costs of public transport and private taxis:

- During our research of NHS websites we found every site to be different and that it was not always apparent where information on travel to hospital or reimbursement of costs could be found.

- There appears to be no mention of reimbursement for taxi fares on any of the NHS websites. This may be because currently the NHS doesn't appear to reimburse taxi fares even though this may be the only way some people can reach their appointments.

- For many people on low incomes the "Help with Health Costs Scheme" and NHS reimbursement schemes don't work because they have to claim in arrears and as such these schemes do not meet their needs or take account of their individual circumstances.

- The National Entitlement Card Scheme is not flexible enough and the 'plus a companion' facility could be widened.

- Many people who have a National Entitlement Card (bus pass) cannot use it, as there are poor bus services (or no accessible buses) in their areas as many of these routes are not commercially viable and services have been withdrawn.

- Hospital parking costs (even for Blue Badge holders) is unaffordable.

- The variation in fares between bus operators made some journeys unaffordable, and not an option, as are rail fares.

- The cost of travel by local community transport schemes can be unaffordable, especially in rural areas where return journeys are long and reimbursement is charged per mile.

7. Conclusions

As a society we need to make sure that every disabled person can plan and get to their hospital or medical appointment. This includes being able to undertake the door-to-door journeys via a transport system that is easy to access and affordable to use. This also incorporates travelling with safely and straightforwardly, without being made to endure anxiety, distress, increased pain or additional costs.

There has already been some productive thinking about how transport could be improved to better support the health system, but it is at a relatively early stage and much more needs to be done.

AS undertook a review of Transport for Health and Social Care in 2011. There is little or no evidenced progress from the recommendations of this review. The ethos of the review being **"good transport services can help the whole health and social care system to work efficiently"**.

MACS phase one research and evidence gathering on Transport to Health and Social Care found many similar issues as reported by AS in 2011, which suggests that the AS recommendations have not been progressed in over 8 years since the audit was undertaken.

This begs the question of leadership and who needs to drive this agenda to gain traction and deliver the improvements required to address the transport barriers for disabled people and older people when accessing health and social care facilities and appointments.

MACS recommendations below are aimed at identifying solutions to some of the obstacles for disabled and older people accessing heath care. This includes recognising areas that are worthy of exploration.

Our recommendations are made to address some of the current barriers and many are based on feedback from disabled people using services and hence formed from their lived and direct experience of the current barriers.

This approach fits with the Scottish Governments commitment to "Democracy Matters" and the recent commitments around the Local Government Review, Developing and Testing Proposals, which confirms that Scottish Ministers and COSLA have a clear expectation that all public sector partners engage constructively in local level discussions to further develop ideas with the most transformative potential.

From MACS work it is clear that people want to be involved in designing the services they use and for their experiences to be used to identify solutions that would reduce inequalities and allow them fair and equal access to health and social care services. As stated, this aligns with the Scottish Government and COSLA's work on "Democracy Matters"[10] and in particular:

- For individuals and communities input to lead to practical action that improves their access to services and experiences.

[10] Scottish Government's Democracy Matters web pages

- To be able to have more influence – having a voice in, and an impact on, decision-making and designing services.
- The need for transparency and accountability – public authorities being transparent about their decisions and communities being able to hold them to account for those decisions.
- Authority – having the authority and resources to take decisions.

People stated that they wanted an end to tokenistic engagement, poor communication, unwelcoming structures, inability to effect change/inaction and the current lack of meaningful representation.

Our approach is also intended to align with the imminent National Transport Strategy 2 and link to the progress required under the 5 ambitions of A Fairer Scotland[11]. Each of these, working towards achieving the outcomes of Scotland's' National Performance Framework[12].

Our approach also involved thinking about and discussing how existing transport resources could be deployed more efficiently, how we could raise awareness of their existence and to recommend how organisations can and should plan and work better (and better together) to improve transport to healthcare facilities.

There are far too many disabled and older people who find it difficult, stressful, often unaffordable, and often physically painful, to get to hospital and medical appointments. There are a number of practical steps that could be taken to reduce these problems across different forms of transport and planning functions.

Transport must be regarded as a key component of an integrated health and social care system and patient care pathway.

If disabled and older people cannot actually get to the services they need then the system will fail, impacting on the individuals health and wellbeing and placing further costs and pressure on our NHS.

Overall we need a more consistent approach to the provision of patient transport services so that the range and quality of services do not differ depending on level of mobility, disability, where you live or what you can afford.

Over the past decade or so, there has been a real shift across Scotland in the way communities are involved in decision-making. There is a recognition that empowering communities to make things happen and influence decisions can lead to more effective and responsive services, again aligning with "Democracy Matters" and the ethos of "nothing about us without us".

However, it has been noted that the views of people with direct lived experience are often used to illustrate a point, rather than to shape agendas, explain or increase understanding of the key issues relating to public transport and service provision failures. It is not always clear what impact involving people with direct lived experience has on policy and practice.

[11] Scottish Government's Fairer Scotland web pages
[12] Scottish Government's National Performance Framework

Therefore, in looking through our evidence gathering and statements/comments from people with direct lived experience, we are not just interested in whether they are and will be heard, but we are interested in what impact this will have and how their views will be used by Scottish Minister, the Scottish Government, Public Bodies and other organisations in the development of their action plans.

8. Recommendations

This MACS Report: Transport to Health and Social Care makes **27 key recommendations** for the Scottish Government, NHS Scotland, the SAS, Local Authorities, Regional Transport Partnerships and the CTA. In comparison it should be noted that many of these recommendation reflect those made within Audit Scotland's report on Transport to Health and Social Care, in 2011 and as such would further evidence the lack of progress with this agenda:

Health transport (provided by NHS hospitals and the SAS) and public transport should cover provision for both disabled people and older people who do and do not qualify for NHS patient transport services but need to get to a medical appointment.

> **Recommendation 1:** The Scottish Government should review the operation of patient transport services to promote consistency, quality, and affordability, while ensuring that disabled and older people are not being unfairly excluded from accessing healthcare. This should align with the 4 priorities of the National Transport Strategy and in particular priority areas 1 and 4 (Promotes Equality/Reduces Inequality and Improves Our Health and Wellbeing).
>
> **Recommendation 2:** Transport should be built in as an integral part of the care pathway. There needs to be better joined up planning and working between the NHS, Local Authorities and SAS. The CTA should be recognised as key partners in these discussions (supported within the Transport (Scotland) Bill legislation).
>
> **Recommendation 3:** Transport should be designed around access to hospitals and other essential services. Organisations must engage in relation to getting disabled people and older people to their services, including with those who use their services.
>
> **Recommendation 4:** One organisation needs to take accountability for the lead strategic planning role (suggested to be Integrated Joint Boards) to ensure ambulance, hospital, community and public transport provision meets demand and is accessible, available and affordable to all (again this aligns with the 4 priorities of Scotland's National Transport Strategy and the recommendations of Transport Scotland's Accessible Transport Framework). Regional Transport Partnerships are also central to these discussions.

Transport resources and budgets could be shared between the NHS, Local Authorities, SAS and Community Transport Operators (budgets should be ring- fenced for transport).

> **Recommendation 5:** This should be explored further.
>
> There is a clear call for integrating resources and call centres to make it easier to identify and book transport, with one overall coordinator for transport to health. **A one-stop shop**. This call goes on to suggest budgets should be shared and ring-fenced and booking transport on-line should be an option. This is supported by a clear call for leadership, joined up working and sharing of resources. This should be explored further.

Recommendation 6: This should be explored further looking at previous successful pilot initiatives (example: the Grampian Health and Transport Action Plan – Hospital Discharge Hub and Travel to Health and Social Care Information Centre – THInC).

Recommendation 7: The SAS should consider introducing the option of on-line booking. Initially this could be done once the person has been through their Patient Needs Assessment and allocated a reference number that would be valid for 3 months. This number could be their gateway number to an on-line booking facility for ambulance transport.

Recommendation 8: Online booking of patient transport services should be explored by the SAS, bearing in mind comparator services disabled people use, to allow them to book online. There could be potential to make the booking system for patient transport services similar to Passenger Assist services on public transport where questions are asked less about one's medical condition and more about one's needs.

There is a call to reinvest in previous pilots and current initiatives that work to sustain funding and maximise opportunities to roll these out as best practice initiatives to drive improvements in transport to health and social care.

- **Recommendation 9:** This should be explored further looking at previous successful pilot initiatives (example: the Grampian Health and Transport Action Plan – Hospital Discharge Hub and Travel to Health and Social Care Information Centre – THInC).

There is a call for free travel passes to be sent out with appointment letters to "tackle" the unaffordable element of travel for people of low incomes.

Recommendation 10: This is worthy of further exploration by Transport Scotland and NHS Boards. This should include exploring the possibility of widening concessionary travel timeframes, including concessionary travel for medical appointments within the scheme (for those on low or restricted incomes and to those who rely on door to door transport services). This would also assist with reducing inequalities in areas where many people cannot use their NEC, as there are poor bus services (or no accessible buses) as many of these routes are not commercially viable and services have been withdrawn.

Recommendation 11: Transport Scotland should explore the possibility of a "plus one" on bus passes (beyond for those in receipt of high level Personal Independence Payments (PIP) or Attendance Allowance.

Recommendation 12: Local Community Transport providers should be involved in the planning of transport to medical appointments, particularly in rural areas – this recommendation may be part addressed in the technical amendment of the Transport (Scotland) Bill.

Not taking escorts is a false economy as patients are having to pay for their escorts separately (to meet them at the hospital) and where this is unaffordable hospital staff are getting diverted from their core duties to provide support that a carer or escort would normally have provided for the patient - There are suggestions that many appointments are being cancelled or missed due to the patients not wanting to attend without an escort. There are also statements on the added stress and anxiety for patients when they are not permitted their carer or escort to travel with them.

Recommendation 13: The SAS should review its escort/companion policies and practices (to ensure a consistent application nationally). A meaningful Equality Impact Assessment, involving disabled people and/or their representatives needs to be embedded within these reviews.

Recommendation 14: SAS refining the Patient Needs Assessment (PNA) – The upcoming review of the PNA must include disabled peoples' opinions and experiences of the service, so that it is more reflective of difficulties around mobility.

There are concerns over the cost to the NHS of missed appointments, which have resulted from transport barriers. This also cause additional stress to patients who have to cancel or miss their appointments, often at short notice (transport cancelled by the SAS) and return to a lengthy waiting list (which will also impact on the referral to treatment time targets). Tackling the transport issues would also address these and wider issues such as the financial implication, the impact on people's health and wellbeing and the potential for the patient's condition to deteriorate while waiting longer for treatment.

Recommendation 15: The full impact and cost of inadequate transport needs to be evaluated and measured to understand the scale and wider impact of the problem. This evaluation should look at the impact on an individual's health and wellbeing as well as the financial implications and bearing on missed referral to treatment times and waiting lists. The scale and impact of the above needs to be known and identified to understand the issues and measure the impacts to influence future financial investments and to enable ambitions 1 and 3 of A Fairer Scotland.

There is a call for data collection and analysis to better understand the wider impacts on inadequate transport to healthcare facilities. This should include but is not limited to:

- Cost of missed appointments;
- Administration costs of rebooking appointments;
- Impact on increased waiting lists and referral to treatment time targets as a result of transport failures (missed and re booking appointments);
- Impact on patient care and patient experience;
- Potential cost of deferred treatment (health and wellbeing and financial);
- Hidden costs of staff stepping into a "carer" role in the absence of the patient being able to travel with an escort or companion to provide this level of support;
- Unclaimed travel budgets/reimbursement funds.

Recommendation 16: The scale and impact of the above needs to be known and identified to understand the issues and measure the impacts to influence future financial investments and to enable ambitions 1 and 3 of A Fairer Scotland (as above).

Recommendation 17: All local authorities should have an accessible transport strategy and targets, which encourages and facilitates more disabled people and older people being able to use public transport to attend medical appointments.

Discharge areas could be made into "discharge or waiting hubs" designed around a more social and shared place and space setting to improve the patients experience and also assist with reducing loneliness and social isolation.

Recommendation 18: NHS Health Boards should engage with patient groups in the design of discharge lounges and transport waiting hubs.

Some people may know about ambulance transport and local bus services but be unaware of possible community transport and other options i.e. British Red Cross.

Recommendation 19: The SAS, Hospitals and GPs need to proactively communicate information on what is locally available to patients who may not be aware of this information. This should include online information and distributing offline information, particularly too hard to reach groups.

Recommendation 20: There should be clearer obligations on hospitals and GPs to offer information about alternative forms of transport where people do not qualify for ambulance service patient transport.

Recommendation 21: All local authorities should consider a well-publicised central information point giving details of all local transport options (including community transport) for getting to medical appointments.

Recommendation 22: Health Boards and hospitals facilities should automatically **consider the patient's transport needs within the care pathway**, to ensure they can get to appointments and receive assistance if required. They should review all the options if a disabled or older person does not qualify for patient transport.

Many disabled people often tell us about the difficulties with insufficient hospital parking spaces for Blue Badge holders. We have been told of some patients having to cancel their appointments because hospital car parks were full and disabled drivers or passengers could not walk from the car to their appointments.

We have heard of people booking ambulance transport only because they have previously been unable to park at the hospital. This misuse of ambulance service resources could be avoided. Feedback suggest that parking arrangements for disabled people at hospitals are unrealistic as they provide only a limited number of accessible/ Blue Badge parking bays, and patients are not allowed to use their Blue Badges in other sections of the car park without a financial penalty (which for many is unaffordable).

Recommendation 23: Hospitals need to review the number of Blue Badge parking spaces and the distance from the clinics/main outpatients. The Blue Badge spaces should be more closely monitored with enforcement to eliminate misuse.

Recommendation 24: There should be a review of any charges for Blue Badge parking with a drive to eliminate costs for disabled people.

Recommendation 25: The facility to pre-book car parking spaces at hospitals and other healthcare premises should be explored.

Recommendation 26: The planning and design of buses, bus routes, bus stops, information points, and public toilets need to be geared towards disabled people and older people getting to hospital and other essential services. Disabled and older people should be given more influence over how transport to hospital works to tackle any difficulties they experience.

Recommendation 27: from SAS/DES Workshop Nov 2019: The Accessible Travel Framework (linked to the National Transport Strategy) should prioritise improving transport access to health and social care in line with their ambition of “more disabled people successfully completing more door to door journeys”.

ANNEX A - Record of the Transport to Health Roundtable

The Transport to Health Roundtable held in Glasgow on 21 November 2019 began with introductory remarks from the MACS National Convener, who thanked attendees for participating.

The Convener explained that she understood this was a long-standing issue and she was aware that the areas being discussed were not new and indeed these are issues that many in the room had been trying to resolve for many years.

The Convener expressed her understanding of the frustration given people's efforts and that, when we listen to what people are telling us, not much has changed and potentially the availability of suitable transport to get to medical appointments had got worse as budgets had been cut, resources stripped back or redeployed and some bus services withdrawn.

The Convener also explained that she recognised the frustration and the fatigue with this agenda given these efforts and the lack of **or** slow progress. **But** - from today's turnout it was evident that there was still an appetite to work together and seek improvements. She acknowledged and welcomed this and thanked everyone for coming along to join in the discussion.

The Convener explained the opportunities to re-energise this agenda with:

- The imminent launch of the National Transport Strategy (NTS2)
- The consultation work of the Strategic Transport Project Review (STPR2) to support NTS2
- The review of the Scottish Governments progress on the Fairer Scotland due in Dec 2019 (transport being key in 2 of the 5 ambitions and an enabler for more)
- The new Annual Delivery Plan model for the Accessible Travel Framework, and
- More organisations focusing their work and strategies around the need for a fit for purpose transport system (such as the Equality and Human Rights Commission, The Poverty and Inequality Commission in Scotland and Disabled People's Organisations).

With these opportunities in the offing, she wanted to gather people's thoughts and talk about some of these issues to allow MACS to discuss them with Ministers in Jan 2020 and make some recommendations that **could/would** deliver improvements. This would include highlighting some areas worthy of further exploration - to enable disabled people and older people to be supported by a transport system that gives fair and easy access to healthcare and is available and affordable for all.

The Convener thanked Transport Scotland officials for helping to organise the event, and representatives from Disability Equality Scotland and the Community Transport Association for reaching out to their members and networks to gather information. She also thanked Badenoch and Strathspey Access Panel, Lochaber Access Panel and Voluntary Action Lochaber for giving up their time and making themselves available to discuss their previous work and the current issues.

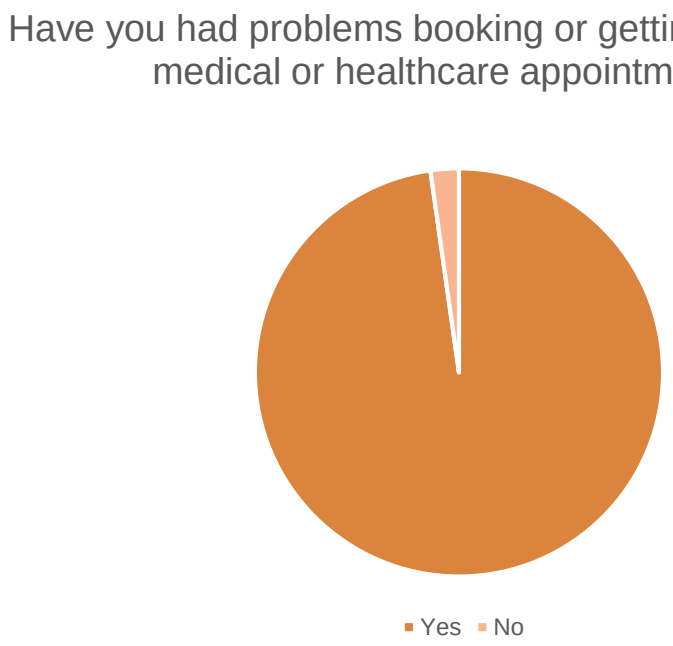
The independent facilitator for the day introduced herself, a member of staff in the Scottish Government. She explained the purpose and structure of the day and touched on some of the background, and explained it was timely to undertake this event.

Disability Equality Scotland (DES) presentation

The next item on the agenda was a presentation from the Operations Manager of Disability Equality Scotland (DES).

DES is a national Disabled Person's Organisation, working across Scotland to improve access and inclusion for disabled people. In August 2019 they ran a weekly poll of its members on the topic, access to transport for healthcare and medical appointments. They also arranged a roadshow in November 2019 where the SAS agreed to meet with DES members and discuss some of these issues in more detail. These findings were discussed in the presentation.

For the week commencing Monday 5 August 2019, DES asked their membership if they had problems booking or getting transport to medical and healthcare appointments. 849 people responded and 98% said yes, while 2% said no:



The poll also asked respondents to provide more information about key issues. These included the following:

- **Concern at carers not being transported on SAS patient transport.** DES members had experiences where disabled people supported by a carer, would not be able to travel using patient transport with their carer, but instead the carer would have to make their way separately to hospital. This caused many people stress and extra expense. Although this policy has changed it still causes concern.

- **Eligibility criteria for SAS patient transport being unclear.** For some patients, there is no clear indication of how eligibility is determined because on different occasions when booking they have answered the same questions, with the same responses but with a different outcome. Sometimes they are eligible and other times not. The Ambulance Service has clarified that the assessment takes place based on the situation at the time of booking. But this still left questions for DES members about what the eligibility criteria actually are, because these are not widely available.

- **Failure to respond to identified need.** There were incidences of patients making their own way to hospital, and then being unable to return home un-assisted after their treatment. These patients were told they were not eligible to use the SAS patient transport service because they had made their own way into the appointment. In response, many patients had relied on friends or family taking time off work to transport them to appointments, but felt that their needs meant they should be eligible for patient transport.

- **A perception that the eligibility criteria for SAS patient transport were biased against hidden disabilities.** For example, a respondent mentioned that anxiety and a lack of confidence meant that using public transport was not an option, then it isn't assessed or recognised as a medical condition. At the roadshow event the SAS explained that the PNA (which is used to determine eligibility for patient transport) would be reviewed in January 2020.

- **Concerns were raised about the reliability of SAS patient transport and public transport.** This is problematic as it can result in missing an important medical appointment. Delays and cancellations were reported for many reasons. Similarly, the frequency of public transport meant that disabled people felt they could not rely on public transport to make early healthcare appointment times. A particular problem was that the Ambulance Service patient transport service might not be operating at times of the day when disabled people need to travel.

- **Particular issues were raised by disabled people in rural areas.** Distance and geography posed special challenges in these cases. The nature of the public transport offering in these areas was flagged up by disabled people. For example, one disabled person's bus service used coaches. These were not accessible and ultimately resulted in cancelled appointments.

- **The accessibility and cost of public transport was problematic for disabled people travelling to appointments, and sometimes not a feasible option at all.** For example, issues were raised about the limited spaces on buses for wheelchairs, which means there is no guarantee that a wheelchair user can travel to an appointment. Also, many of the bus routes did not go close enough to hospitals or medical centres – particularly direct routes, so could result in a number of changes. Public transport can also be expensive, with many patients having to use taxis, which they couldn't afford. The frequency of journeys also made the cost untenable.

Quotes from DES survey

> "I really need my carer to attend the hospital with me but the ambulance service no longer allows this so I can't use ambulance transport and have to pay for taxis that I can't afford. I wouldn't manage by bus."
>
> "I've had an experience where I was found to be eligible for patient transport, only to be rejected on a subsequent follow up appointment. Where is the consistency?"
>
> "Lengthy delays to return home by ambulance often means I am really unwell by the time I get home."
>
> "I live north of Inverness and have regular appointments at Raigmore. Around a year ago our bus was replaced by a coach (Stagecoach) and the steps on the coach are too high for people with mobility impairments…this is the only bus on the route. Being rural we have no train service, many medical appointments are going unattended and cancelled which I am sure is wasteful to the NHS."
>
> "On the days I have to travel to hospital I have to skip a meal to afford the travel. I don't mind doing this because I need to see the nurses and doctors, but should this really be the choice?"

Taking stock of these findings, the question was raised: What needs to change? Based on the findings of the work DES had undertaken, they proposed the following:

- **Refining the Patient Needs Assessment (PNA)** – The upcoming review of the PNA must include disabled peoples' opinions and experiences of the service, so that it is more reflective of difficulties around mobility.
- **Integration** – A joined up approach between the SAS and hospitals to ensure those who are eligible for patient transport are given appointments during SAS operating hours.
- **Information –**Information about patient transport must be available in a variety of accessible formats, with an understanding that not all people can access information online.
- **Public Transport –** Build stronger relationships with transport providers to ensure alternative means of travel are available to patients not eligible for patient transport services.
- **Funding** - Funding is required to achieve meaningful change, to both restructure the system, improve communication between service providers as well as increase the capacity of the service.

The facilitator opened the discussion to the floor for reflections and comments about the DES findings. During this session the following points were made:

- The ambulance service does not have the resources to meet all the potential demand for patient transport. But if we could get elements like the public transport system and parking at hospitals right, so that it was accessible and affordable, then pressure could be taken off the ambulance service.

- A participant asked the room if others had examples of cases where transport to health was added to and an integral part of someone's care pathway, rather than just being something the patient has to organise themselves because it's seen as distinct from the care provided. She asked if the participants at the meeting felt that was a good idea.

- Noting the issues raised in the DES presentation, a participant said that rural transport was an important issue. But decisions about such transport were being made without full facts, like the number of missed appointments. There is ambivalence about whose responsibility it is to get people to appointments.

- A participant said that a lot of people associated the ambulance service with emergency transport. This was not correct, given the significance of the patient transport service. Moreover, it was important to separate outpatient transport from other public transport services.

- A participant reflected on her experience about parking at hospital where people who didn't have Blue Badges were using Blue Badge spaces. She commented that stress about finding a parking space drove the demand for other services. Separately, she felt there are opportunities for the third sector to work alongside partners to develop services to support people getting to healthcare appointments, not least to raise their profile. A key issue was who takes responsibility for transport to healthcare. At the moment that rests with the individual, to find a needle in a haystack. We need to make accessibility matter and it doesn't feel like that's happening.

- A participant reflected on hidden disabilities and anxiety, she distinguished between chronic anxiety and a lack of confidence when travelling. She felt more work ought to be done in making information available for travellers. This would help improve people's confidence to travel.

- A participant said that parking is a significant issue, with very limited monitoring of parking use in the hospitals. For example individuals park their cars very close to others, and make it difficult for people to access bays. She noted that Glasgow Disability Alliance members felt there was a lack of basic customer service when booking patient transport on the phone. Turning to the idea of introducing transport as a feature of care pathways, she mentioned that given the pressures on basic social care it seemed unlikely to happen in the near term.

- A participant said their needs to be a high-level, joined-up approach to **make accessibility matter**. At the high level of a number of transport organisations, people didn't understand the full range of accessibility needs. So there was a need for this joined-up approach to be undertaken. Also, she noted that traditional public transport often isn't the right answer for some areas and imagination was needed to design appropriate solutions.

- A participant said that he managed an integration project in Strathclyde where the ambulance service was unhelpful and obstructive. On the patient transport eligibility criteria, he felt a lot of questions needed to be answered. He didn't feel that just getting public transport right by itself was the answer because of people who couldn't use public transport.

- One participant agreed that there was a significant lack of transparency in how the patient transport service works from the Ambulance Service. It was also important to bear in mind that the subject of transport for disabled people went beyond disabled people and shouldn't just be seen as a transport issue. It was as much a public health issue. It was disappointing that this was not fully recognised by the public health community.

- A participant said that people with dual sensory impairments couldn't phone to make appointments. Issues have arisen where carers or guides/communicators have been refused admission to a patient transport ambulance. A system that reflects the full range of accessibility requirements is therefore needed.

- One participant asked if there was further information about the review of the Patient Needs Assessment? The convener reported that the Ambulance Service said that they couldn't disclose the assessment because of the complexity of the algorithms. At the DES roundtable the ambulance service confirmed they were reviewing the assessment and DES explained that, the review needs to be person-centred and have meaningful engagement with disabled people.

- A participant backed a point previously made, and gave an example from her experience with Shetland Islands Council where there were no commercial (non-subsidised) bus services, and it was difficult to provide more accessible services. She also noted that there were resource pressures on local authorities, so the idea that more than the legal minimum would be provided for is unrealistic. Another participant agreed with this point and said that until the legislation is changed, it is difficult to foresee progress. **So we need the politicians to come to the table, and stay at the table.**

- NHS Lanarkshire provided an example of work they are doing in this area. They are developing a transport hub. They're at the very early stages of development but it would be useful in providing a single point of contact. NHS Lanarkshire recognise that they have to be part of the solution rather than just transferring responsibility. It was important not to demonise the Ambulance Service as they too had a responsibility.

Concluding the morning session, the facilitator thanked everyone for their contributions. She noted themes about hospitals – not just lack of Blue Badge spaces, but concerning their design.

Issues around public transport featured and bus stop locations in relation to out-patient departments as did issues about the capacity of the third sector.

Issues around hidden disabilities were mentioned alongside a theme that there is a general lack of information and booking processes are complicated and inconsistent.

Table discussions

Each table (comprising a mix of participants with different experiences and perspectives) was given a particular topic to look at. The results were discussed after a presentation from MACS.

Presentation on Local Outcome Improvement Plans (LOIPs)

A MACS member spoke about Local Outcomes Improvement Plans stating that there are two main drivers for locality planning: the first is the law that brought about integrated health and social care services and the second is community empowerment legislation. The MACS member then went on to explain the background to Community Planning Partnerships and their requirement to produce a LOIP.

MACS analysed all LOIPs published in all 32 Local Authority areas in Scotland and noted that there was very limited information related to transport, and even less concerning transport to health. One local authority excluded a number of potential outcomes on the basis that a significant number of people didn't mention transport and acknowledged that the issues would be dealt with via another medium; for example within the Locality Plan for that area.

Local Outcomes Improvement Plans research results

On reviewing Local Outcomes Improvement Plans (LOIPs) the main finding was that there is no national outcome around transport provision to health. During research MACS found areas of good intention/good practice as below:

- **Inverclyde** focus most on transport to health and used the Place Standard Tool when engaging with communities. Their LOIP acknowledges that supporting older people and that attention should be focused on addressing issues such as transport and healthcare provision.
- The **City of Glasgow** refers to Health as a priority (page 10 of their plan) and transport was a recurring theme in terms of being a barrier. They focused on connected transport that links people to healthcare.
- **Engagement with communities within Falkirk** highlighted issues around transport and its affordability.

Generally, within the LOIPs, there was a lot of focus on modal shift from cars to sustainable transport solutions and improving transport connectivity within Scotland's towns and cities including the Islands.

Roundup of Group Discussions

The following sections provide an illustrative sketch of the group discussions, which took place during the roundtable:

Group 1 – Topic: Accessible public transport

The first group felt it was important to remember that good accessibility supports a wide range of other positive outcomes in areas like social isolation, recovery, poverty and inclusion. The group considered barriers to accessibility; issuing travel passes with appointment letters was suggested, organisations needed to look at accessibility in a holistic way. For example, benefit could be gained from looking at NHS travel staff patterns and using that to look at the potential for provision of new public transport services.

The group proposed a number of practical ideas for change, recognised the importance of enforcing the Blue Badge scheme in healthcare premises and punishing misuse. It also suggested making the National Concessionary Travel Scheme available so that people could get free travel on all types of community transport. This would assist in areas where there was limited or no bus services.

The group considered that collaboration is key to ensure end users are appropriately supported. For this reason having national accessible travel outcomes is important, but collaborative delivery of these at local level is key.

These reflections and suggestions are cited within the recommendations of this report.

Group 2 – Topic: Booking and Information

This group rapidly recognised that the map of existing services is complicated. For example, the ambulance service had one set of criteria while some community transport organisations disabled people may go to for transport to hospital might only help older people. This was a confusing and difficult environment for disabled people to navigate, especially with so much local variation. Therefore the group felt it was a good idea to have a single point of contact disabled people could rely upon to help navigate this.

One model that the group felt could work is improving the existing ambulance service patient transport call centre. In cases where someone is ineligible for ambulance transport, instead of being provided with a list of phone numbers of relevant organisations, it could refer to appropriate intermediaries to directly book onto relevant services such as community transport.

Suitable software could be used and joint working with other bodies like NHS 24 would also be helpful. Indeed, the group felt that other bodies might be better placed then the ambulance service to undertake this kind of work in supporting disabled people to access healthcare appointments.

There were a number of other points the group raised as relevant to tackling the issues.
The group felt the review the ambulance service will undertake of PNA ought to be undertaken in close collaboration with patients. There was also an idea that accessibility should be included in the Charter of Patient Rights and Responsibilities.

These reflections and suggestions are cited within the recommendations of this report.

Open discussion:

At this stage, there was significant open discussion among participants. In discussion the following points were made:

- A number of participants expressed agreement with the idea of a one-stop shop along the lines proposed. One participant said the technology was already there to deliver such a service. Another mentioned an example of how such services worked well in other contexts.

- A participant gave an example of how services can work well together to reduce the burden on disabled people of finding information about, and booking, suitable services to get to healthcare appointments. In Aviemore the local community transport organisation helps local people reach podiatry appointments on a street-by-street basis. Being with one's neighbours when travelling also helps to make the experience of attending the appointment more pleasant.

- Some participants expressed caution about the implications of some of the ideas. One mentioned that it was important to bear in mind the budget for the concessionary travel scheme was limited. Another participant indicated that the NHS faces considerable resource pressures.

Group 3 – Topic: Availability

The third group focused on patient transport services run by the ambulance service. The group looked at existing pain points and suggested the following solutions:

- On-line booking of patient transport services, bearing in mind comparator services disabled people use allow people to book on-line.

- Making the booking system for patient transport services similar to Passenger Assist services on public transport where questions are asked less about one's medical condition and more about one's needs.

This group raised other ideas ranging more widely. So it suggested there should be a facility to pre-book car parking spaces at hospitals and other healthcare premises. And they strongly supported the idea of a one-stop-shop, bearing in mind that no ambulance transport service could pick up all demand for transport to healthcare services.

These reflections and suggestions are cited within the recommendations of this report.

Group 4 – Topic: Community Transport

The fourth group looked at how community transport can help to bridge gaps in transport services. It began by noting that there was a right to healthcare, but no corresponding right to transport. Given this gap, the group felt that transport providers are generally missing from conversations about healthcare. There was a connected point in this respect about whether disabled people's statutory rights should be bolstered.

A live question was what the role of a community transport operator should be. Much of the work community transport operators undertake in this area is filling gaps left from reductions in statutory or commercial public and patient transport services. Whether "more community transport" was the correct answer to the problems identified in this roundtable was not clear but there was a general consensus that they should be around the table for the transport planning meetings.

Bearing in mind that many community transport services are volunteer-led and particularly with respect to long journeys, it was important to be both fair about the expectations being placed on volunteers. A particular challenge was – where only those with full driving licences issued before 1997 could drive a minibus without undertaking another driving test – this loomed large. This could have an impact on the sustainability of community transport services being used now as less people had the D1 and D2 categories on the licence.

The group felt this all required some long-term thinking about the design of services. The group suggested some centralised hubs to deal with administration and booking could help free up resources within community transport organisations.

Joint procurement of services was also suggested. Introducing some form of National Voluntary Service was a bolder suggestion, but reflective of the challenge this group identified of maintaining levels of personnel.

These reflections and suggestions are cited within the recommendations of this report.

Group 5 – Topic: Affordability

This group developed a series of principles. These reflected how an ideal system would look:

- Transport to healthcare services is free to those that need it.
- People are to be referred or self-refer for such support.
- When the system does fail, and as such people are having to make their own arrangements, reimbursement will be undertaken by NHS.
- Phone calls to patient transport should remain free.
- Any carer travels for free.
- Any overnight accommodation is easy, quick and reflects the costs.

The group reflected at this stage that living cost is a particular challenge for rural areas, in particular. Things like work cost, childcare cost, and so on, all have to be borne in mind. In an ideal situation innovative solutions would be developed. **For example it might be possible and more cost effective for a hospital consultant to move to see patients, rather than vice versa**. Or IT solutions could be developed to reduce the number of times people have to travel.

The group itself acknowledged that many of its principles were very ambitious and deliberately reflected an idealistic look at what the situation could be like. It therefore made a number of other suggestions.

- It felt the application and assessment process for ambulance service patient transport could be made simpler.
- A key consideration in decision-making about healthcare services (where they are placed, how integration with social care takes place, and so on) is that the "purple pound" of disabled people's spending power is not affected.
- They also felt that a continued focus on the accessibility of public transport needed to take place. For example, the group agreed with an earlier point about going beyond existing legislative standards of bus design. By giving people greater assurance their journey could easily and successfully be undertaken by public transport, this would reduce the need to undertake the journey using more expensive modes like taxi.

These reflections and suggestions are cited within the recommendations of this report.

Group 6 – Topic: Roles and Responsibilities

This group felt overall responsibility for transport to healthcare services should rest with the Cabinet Secretary for Health in the Scottish Government.

At operational level, they wanted a 24/7 call centre to exist, which they felt could be run by the Scottish Ambulance Service although other organisations could do this.

The group worked out a schematic for how an optimised service could work, similar to the proposed **one-stop-shop** discussed above. But they proposed some changes from the proposal made earlier. For non-urgent patient transport they felt that the **one-stop-shop** should directly book individuals onto services, including new services that could be set up to meet the demand.

They made a number of suggestions that ranged more widely. Trip sharing services, like those offered by Regional Transport Partnerships, could be used in this area. Reducing the number of times in-person attendance at healthcare premises should also be considered.

Parking at hospitals needed to be tackled rigorously.

This group came up with an idea about a statement of ambition. **They felt developing a Patient Assist service should be the aim**. This would take some of the lessons from Passenger Assist services when someone wants to travel by air, ferry or rail would be a good goal. This would provide a wraparound service of assistance based on need and meeting consistent standards, helping people make their journeys to healthcare settings.

These reflections and suggestions are cited within the recommendations of this report.

Group 7 – Topic: Accessibility, Affordability and Availability

The group agreed with a lot of the points made by other groups. On accessibility, the group felt the range and coverage of public transport services, good infrastructure like paths, pavements, tactiles, crossing points, bus stops, accessible vehicles, and fares (including the scope of the National Concessionary Travel Scheme) all needed to be examined.

The group agreed that many people who have a National Entitlement Card (bus pass) cannot use their bus pass, as there are poor bus services (or no accessible buses) in their areas as many of these routes are not commercially viable and services have been withdrawn.

This group also supported the idea of a **one-stop-shop** but came up with further ideas for how to make it work. In particular, they proposed a better relationship between the booking centre and the hospital. The **one-stop-shop** should facilitate better dialogue between the healthcare provider (such as the hospital) and transport providers, in the interests of the patients.

The group provided an example of how a one-stop-shop might be innovatively designed.

NHS 24 and the SAS decided to co-locate to handle calls and route them to the right clinician be in GP, community nurse or paramedic. From working together physically the inefficiencies have been pulled out from the system.

The group also explored other issues. They felt that it was important to move the thinking of local health and social care systems away from looking at costs and benefits and isolated targets, but towards holistic user outcomes. If this were done then transport to healthcare would be considered more of a priority and part of the care pathway.

They also felt that there should be a presumption that it is best to build new healthcare facilities with strong links to public transport.

For some of the newer builds of such facilities consideration needed to be given to how disabled people move from site to site within a campus, not just how they get to the campus.

The group spoke about the current variations of bus designs and stated that a basic principle should be that all vehicles are accessible to everyone and designed in partnership with users. They gave an example of the “Glider Buses” in Belfast where this approach had been taken from the very outset of thinking about new buses, routes and timetabling. They confirmed that any bus operating on a local bus route should be accessible to all.

The group discussed bus stop design and agreed that all bus stops should comply with a minimal standard of design based on guidelines for accessibility.

The group spoke about the value of and valuable service provided by local community transport schemes, the users satisfaction, confidence in the schemes and the bespoke door-to-door service these schemes provided. They felt that there should a push to invest and sustain the community transport schemes given these factors and benefits.

The group noted that their thinking on this subject had been constrained by costs verses benefits and what would be deemed affordable or where money would come from. There was an agreement that the overriding principle should be person centred and focussed on what access to suitable transport enables and the wider societal benefits investments would bring.

A general discussion took place on the possibility of electric shuttle vehicles (i.e. golf type buggies, MPVs) to connect patients getting off at the nearest bus stop with the hospital cite and also within the hospital or campus, as many had difficulties with these distances and the last stretch of the journey.

These reflections and suggestions are cited within the recommendations of this report.

Closing reflections

At this stage there was a final open discussion among all participants, to ensure any closing reflections were recorded. During this discussion:

- A participant raised the point that privacy had not been raised in the discussions. Data sharing could be an issue in this context. Ensuring any **one-stop-shop** solution complied with GDPR was important. Another mentioned that solutions for this have been found previously.
- A participant underlined the importance of healthcare appointments in the round, not just hospital appointments, which aren't the majority of interactions. GP and dental appointments posed just the same challenges.
- A participant agreed with a lot of the discussion on community transport. The feedback she had received about such services was that when disabled people used them, they felt more confident in travelling because of the nature of the service being provided i.e. tailored to their need, door to door and friendlier volunteers.
- A representative from Highland & Islands Transport Partnership (HITRANS) mentioned their recent successful funding application to make a single booking system for organisations like car clubs. This would be region-wide using a few of our existing platforms already. This spoke to how the technological challenges of some of the ideas mentioned, like a **one-stop-shop**, could be addressed.
- A participant gave example of when two villages lost their GP. She felt it was positive that the CTA represents a community transport organisation that has stepped up with a bus services. But it begs the question about the extent to which we would like local services to exist.

The convener thanked everybody for attending, and also the facilitator for their work. She confirmed that, in January 2020 MACS would meet with Scottish Ministers to discuss the issues raised.

Participants were informed that a report would be drafted comprising a record of discussion and advice from MACS to Ministers based on the day's contributions and the wider research work undertaken.

The report would identify recommendation based on the suggestion and proposals from the 1,000 plus engagement/voices in the run up to the roundtable and those put forward and discussed at the roundtable.

Appendix 1 – List of organisations attending the Roundtable Discussion

ORGANISATION
Aberdeen City Council
Aberdeenshire Council - Passenger Transport Unit
Badenoch and Strathspey Access Panel
Community Transport Association
Community Transport Association Scotland
Confederation of Passenger Transport (CPT) UK
DeafBlind Scotland
Directorate of Health Finance
Disability Equality Scotland
Dumfries and Galloway PSP (Annandale CT)
Dumfries PSP and SPT PSP
Equality and Human Rights Commission
Equality Unit
Facilitator
Glasgow Disability Alliance
Go Upstream
Guide Dogs
Highland & Islands Transport Partnership (Hitrans)
Local Authority Transport Coordinators (ATCO)
Lochaber Access Panel
MACS
NHS 24
NHS Ayrshire & Arran
NHS Ayrshire & Arran - East Ayrshire
NHS Equality & Diversity Lead Network (NHS Ayrshire & Arran)
NHS Equality & Diversity Lead Network (NHS National Services Scotland)
NHS Equality& Diversity Lead Network (NHS Greater Glasgow & Clyde)
NHS Lanarkshire
NHS Scotland Transport & Logistics Services Expert Group
Out of Hours Urgent Care and Optometry Team
Shetland Transport Partnership (ZetTrans)
South-East of Scotland Transport Partnership (Sestran)
Strathclyde Partnership for Transport (SPT)
Tayside and Central Scotland Transport Partnership (TACTRAN)
The Bridge - Third Sector Interface (TSI) for the Scottish Borders
Transport Scotland