Mobility and Access Committee for Scotland (MACS)

March 2020 Development Day @ Edinburgh Corn Exchange

Theme: "Transport to Health - Working Together To Deliver Improvements"

Background: The aim of this event was to engage key stakeholders on the recommendations of MACS phase one work on Transport to Health and Social Care.

- To hear directly from lived experiences (in person or through representatives)
- To review, focus and prioritise recommendations
- To understand/model how to best frame the conversation
- To agree next steps

MACS report from their phase one work was circulated to all attendees in advance.

The event attracted a valued mixture of people from Community Transport, Scottish Ambulance Service, NHS, Third Sector, Disabled People Organisations, Disability Organisations and those with lived experience of transport to health.

Linda Bamford, MACS Convener, introduced the day and set out the challenge. In particular she reminded all of us that there was little change since the Audit Scotland review, report and recommendation on Transport to Health and Social Care in 2011. Meantime things had worsened, not least since the change in the Scottish Ambulance Service's (SAS) patient needs assessment (PNA), which changed the qualifying conditions, the escort criteria and the introduction of a demand capping system resulting in a large number of people seeking support elsewhere. The above actions by the SAS having significantly reduced the number of people the transport on a daily basis.

Karen Armstrong, Team Leader, Accessible Travel Policy @ Transport Scotland gave an overview of the key discussions and outcomes from MACS winter session of Ministerial meetings.

The morning session was focussed on input from a range of people involved in the transport and transport to health sector. This was to improve the audience's knowledge of the current context, alongside the previous briefings and reports produced by MACS.
Unsurprisingly the first to present was Sam Richie, Head of Scheduled Care Services @ SAS. She presented on their current context and confirmed they planned to review their service provision model soon.

Sam faced a number of questions. Many that illustrated the gap between policy (the SAS service model) and lived/direct experiences. There was a strong recommendation of the need for meaningful involvement from those who used the service in the redesign. It was voiced that several people did not experience the service as person centred. The ability of carers to travel with patients to appointments was an issue for many and they identified that the psychological impact of attending health services was not fully appreciated.

The booking process was also an issue with some people finding it inconsistent, often over subscribed and that they were more likely to get ambulance transport when their clinician or healthcare professional "stepped in", although people only tended to ask for this intervention as a last resort.

Bernard Anderson had travelled from the Western Isles (Barra) to tell the group about the challenge attending healthcare appointments for those on the islands. Bernard gave an overview of the opportunities for using a remote link like NHS Attend Anywhere, coordinating appointments with travel (and not going to the back of the waiting list if travel problems affect appointments) and joining journeys with others when possible. Attendees from the mainland were really struck by the impact and the complexity of accessing healthcare for island patients.

Andrew Stewart from NHS Grampian (Health and Transport Action Plan Project Manager) described best practice in a service, which is jointly funded by NHS Grampian and NESTRANS, a unique and impressive example of partnership working. The programme has been developed to co-ordinate partnership working between agencies in the areas of promoting active travel, improving the links between transport and public health and access to healthcare. He highlighted the benefits of the THInC project, which helped people access health and social care services.

Emer Murphy, Deputy Director of Community Transport Association (CTA) in Scotland, introduced the research she had done on the role and experience of the CTA's with regard to transport to health. Her survey was completed by 67% of the audience.

A return that was excellent and showed the level of interest in this issue.

The full report is not yet available but there were a number of themes already emerging. There is an inequality of access across the country and clients are often surprised that there was a payment. They felt there was an important need and opportunity to work with other partners to join up the service.

A snapshot of the findings from Emer's survey is available within MACS report on Transport to Health and Social Care (page 9).

The afternoon was structured to work at tables to identify what people noticed most and thought were underlying causes of these issues and then time was taken to discuss, review and prioritise the recommendations.

Question: What did you notice most from the report and today's contributions and what may be the underlying causes to take account of as well?

Several themes did arise:

There needs to be a review of the Scottish Ambulance Service scheduled care service and this review should be done by an organisation independent to the SAS.

A joined up service is needed, as a disconnected service is inefficient and confusing and stressful for users. A single point of contact is needed to avoid people being treated differently. There are many small local initiatives but they need to link up to offer the service as one.

Communication is poor between those who offer different parts of transport to health. Silo working was acknowledged. There is also a need to listen to hear properly what is being communicated and not to defend when challenged.

Budgeting issues are part of the lack of joined care. One organisation should be the lead and accountable for progressing and maintaining this work and ensure the focus us to meet people's needs appropriately.

Inequalities are deepened by the lack of prioritisation, a stretched budget and a need for clarity of what a good service looks like.

The cost of missed appointments was identified as a significant issue and that a system that worked better would save a budget that could be transferred to improve it more. Appointments could be linked better to people's situations looking at either geography and travel times with transport or not giving early appointments to older people.

It was suggested that other initiatives might not help this issue i.e. the Accessible Travel Framework does not focus on this issue and it should.

It was voiced that Active travel can actually disenfranchise older and disabled people and again not link up to this agenda even given the recent large investment through Programme for Government.

Redesign of healthcare is needed to include how the person gets to appointments in primary, community and secondary care. Transport needs to be part of the care pathway. Also are all appointments necessary or could they be delivered differently example; by a local member of the care team or by tele-care, email, what's app or SKYPE/Zoom for digital consultations.

Question: What recommendations are right (from the MACS report from the earlier round table) and are there gaps?

The recommendations were well received and the gaps identified were:

Accessible Travel Framework is good but doesn't fit with healthcare policy. This should be explored and reviewed by Transport Scotland's Accessible Travel Policy Team.

There is a need to state clearly that patients and users of the service MUST be part of design, planning and any changes to services.

There needs to be more recognition of different health care settings, as so far it's tended to focus on simply acute services.

Claiming back travel costs is difficult and hard to identify. The system assumes people have the spare money to pay travel up front.

There would be a benefit to widening up concessionary travel to include a Plus One to cover the cost of people travelling to health appointments with a carer or friend to support them (when this is the only option as they do not meet the criteria for ambulance transport or have been refused an escort).

Recommendations prioritised:

Each person was asked to identify his or her three top priorities. There was some overlap as well so the following are the summarised and merged priorities in order of preference.

Recommendation One

Transport should be built in as an integral part of the care pathway. Their needs to be better joined up care planning and working with NHS, Local Authorities and SAS, with CTA recognised as key partners in the planning and care pathway.

Recommendation Two

Missed appointments should be seen as a priority for this work. Missed appointments that have resulted from transport barriers have a cost to the health service as well as to the individuals and their carers (including being detrimental to their condition through delayed treatment). Ideally this would be quantified to identify financial implications, health and wellbeing complications and the potential for the patient's condition to deteriorate while waiting longer for treatment.

Recommendation Three

Transport should be designed around access to health and social care. Organisations must engage with getting disabled and older people to their services. Transport resources and budgets should be shared between the NHS, Local Authorities, SAS and CTA's (with those budgets ring fenced).

Recommendation Four

One organisation needs to take the strategic lead for planning of the cross sector transport to health service. This must ensure that ambulance, hospital, community and public transport provision meets demand and is accessible, available and affordable to all. Local transport providers should be involved in the planning of transport particularly in rural areas.

Recommendation Five

Disabled and older people should be given more influence on transport to health services and the planning and design of buses, bus routes, bus stops, information points and public toilets to ensure they are geared towards disabled people and older people accessing health services. Transport Scotland should consider including plus one on bus passes for those on PIP.

Recommendation Six

Online booking of patient transport services should be explored by SAS. A booking system like passenger assist of public services, which is a needs based and person centred process.

The SAS, hospitals and GPs need to take responsibility for proactively giving information on what is available locally for transport to health including what's available should the

person not qualify for patient transport. Information should be in accessible forms and suitable to the population it serves. This would include both online and printed form.

Recommendation Seven

People report issues with accessible parking at healthcare, especially hospitals. Blue badge holders report insufficient Blue badge spaces and those available being used by non-blue badge holders. This also results in missed appointments and there are situations when people are asking for patient transport because they cannot park even when they have transport. This needs to be addressed and prioritised to ensure enough spaces and that these spaces are monitored to eliminate misuse.

Recommendation Eight
All local authorities should have an accessible transport strategy that encourages and facilitates more disabled people and older people being able to access public transport.

Recommendation Nine

Improve discharge or waiting hubs to be more like a social and shared space to improve social connection and reduce loneliness. NHS providers should involve patient groups in the design of these.

In conclusion, Linda thanked all the contributors, the facilitator and the attendees. She noted that MACS would retain a focus on and an interest in this area. MACS will continue to engage with Ministers and key stakeholders to advocate the need to move things forward.

Audrey had conveyed her hope that the coronavirus would encourage changes in how we work and communicate and in the words of one of the attendees 'there should be a culture of challenge and critique to help raise the bar and deliver constructive improvement'