NHS
National Institute for
Health and Clinical Excellence

# Accessibility planning and the NHS: improving patient access to health services

## Introduction

Accessibility planning aims to promote social inclusion by helping people from disadvantaged groups or areas to access jobs and essential services (Social Exclusion Unit 2003). As part of their 2006–11 local transport plans, local transport authorities have to prepare an accessibility strategy by 31 March 2006, aiming to develop and deliver solutions to accessibility problems in their areas. These will involve local authorities and the NHS assessing more systematically whether people can get to healthcare facilities, food shops and other destinations that are important to people's health – and taking action to improve access and contribute to tackling health inequalities.

This briefing is aimed at:

- NHS managers and board members dealing with service reconfiguration, the location of services, the Local Improvement Finance Trust (LIFT), and health service planning in general
- Local authority transport planning and health policy officers and elected members, especially those concerned with the health aspects of accessibility planning and the local transport plan process
- Practitioners working to reduce health inequalities and/or enhance social cohesion and inclusion.

It provides an overview of accessibility planning, highlights the role of the NHS and describes some examples of current approaches. This briefing is part of a series of publications from the National Institute for Health and Clinical Excellence (NICE) and the former Health Development Agency (HDA). (See page 15 for a full listing and other sources of information.)

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## What is accessibility planning?

Accessibility, in this context, is whether people – particularly those from disadvantaged groups and areas – are able to reach the jobs and key services they need, particularly healthcare, education and food shops, either by travelling to those services or by having the services brought to them (DH 2004).

Accessibility plans provide the framework for transport authorities and other relevant agencies, such as the NHS, to work together to develop and deliver solutions to accessibility problems depending on the particular needs and priorities of local areas.

Accessibility planning can also be influenced by decisions on the location, design and delivery of other services and by people's perceptions of personal safety.

This publication was commissioned by the Health Development Agency (HDA) but published after the HDA's functions were transferred to the National Institute for Health and Clinical Excellence (NICE) on 1 April 2005. This publication does not represent NICE guidance.

The process involves local authorities and other agencies systematically assessing whether people can get to places of work, healthcare facilities, education, food shops and other destinations that are important to local residents.

> 'The cross sector links [*with the NHS*] will be important to ensure that the transport system best meets the needs for patients and their families and carers and that health services are delivered to maximise their ability to meet people's needs.' (DH 2004, p. 4).

Department for Transport guidance (DfT 2004) sets out the following five stages in accessibility planning. The related Department of Health guidance on accessibility planning (DH 2004) highlights the NHS contribution at each stage (given in brackets below):

- **A strategic accessibility assessment at the unitary, county or metropolitan area** (the NHS can identify the main accessibility challenges at its sites and provide this information to the local authority)
- **Local accessibility assessments focused on priority areas, groups and issues identified in the strategic assessment** (the NHS can provide reviews of existing consultation information, NHS staff time and expertise to contribute to the assessments, or may facilitate new surveys or consultations with staff, patients and visitors to NHS sites)
- **Appraisal of options to address these priorities** (the NHS can help identify transport options, mobile service delivery, and changes to the design or location of NHS services to tackle access problems)
- **Development of joint accessibility action plans** (the NHS can support the delivery of these action plans and, where appropriate, lead on actions to change health service design, delivery or location)
- **Monitoring and evaluation of action plans** (the NHS can contribute to the monitoring and evaluation of access to its sites and services).

Joint working on accessibility planning will involve data sharing and a common approach to modelling between transport planners and NHS managers. There are also opportunities to share costs involved in geographical information system (GIS) mapping and in undertaking surveys and consultation exercises.

The Department of Health sets out the potential benefits to the NHS of participating in accessibility planning (DH 2004, pp. 13–14). These are:

- 'Increasing understanding of transport related accessibility issues
- Informing service planning decisions
- Engaging local transport planners and providers in the health agenda
- Supporting work to improve access and meeting access targets and choice
- Supporting work to improve health and reducing health inequalities, and meeting targets
- Encouraging greater awareness of healthy travel options, ie walking and cycling
- Developing better relationships with local partners.'

## Accessibility indicators

The core standard transport indicators relevant to the health sector are:

- Access to hospitals: percentage of households, and percentage of households without access to a car, within 30 and 60 minutes from a hospital by public transport
- Access to GPs: percentage of households, and percentage of households without access to a car, within 15 and 30 minutes from a GP by public transport.

Local authorities and NHS organisations may need to work together to develop additional local indicators that are meaningful and useful to both sectors and reflect local circumstances. There is an opportunity for the health sector to identify one or more critical local indicators to be tracked in the local transport plan (DfT 2004).

## Learning from local practice

This section summarises the lessons learned from emerging work in the NHS on accessibility planning. The next section presents case studies of current practice in some NHS organisations piloting accessibility planning work. For more information see the relevant sections on page 15.

### *Reasons for local NHS action*

NHS organisations have identified the following reasons for taking action on accessibility:

- Lack of adequate data on transport access to current services
- NHS redevelopments and private finance initiative hospitals
- Access problems for key groups (eg those with mobility problems) or key areas
- Need to develop travel plans for particular NHS sites, often linked to planning applications for development
- Auditing as part of a review of the local transport plan, eg a health impact assessment
- As a result of issues raised in wider community consultation on local issues
- As part of a review of existing NHS services where patients/staff/visitors have identified a problem.

## *Types and sources of NHS data on accessibility*

NHS organisations cite problems in assessing the accessibility of their sites due to lack of available data. The types of data most commonly sought are:

- Mapping data about existing NHS services and current transport provision
- Mapping data about transport provision against patient/visitor/staff demand (particularly for rural areas, people with disabilities, deprived estates, etc)
- Community-wide travel surveys
- Use of, and satisfaction with, specialist NHS transport
- Use of, and satisfaction with, existing public transport to NHS sites.

The following list illustrates the range of potential data sources that may be available locally without commissioning new surveys.

- Reviews and surveys from community health councils, patient forums, scrutiny committees
- NHS access surveys (for hospitals, health centres, GPs, dentists, etc)
- Community needs surveys
- Health impact assessments of local transport schemes that may include consideration of access
- GIS information on public transport services to NHS sites
- Household surveys on distance from a bus stop/bus route to the hospital, and on travel modes
- Use of specialist services to NHS sites – community transport schemes, voluntary care schemes, non-emergency patient transport services
- Patient satisfaction surveys
- Pre- and post-demand for new bus services to NHS sites
- Travel plan surveys (if include patients as well as staff).

## *Options for change*

On the basis of these data sources, NHS organisations can take the following actions to improve access to NHS sites:

- Develop travel plans for new NHS sites and facilities
- Introduce travel plans to existing NHS sites
- Develop integrated public sector transport services – including health, education, social services and ambulance services
- Improve bus services
- Improve tram and rail services
- Improve park-and-ride facilities
- Improve walking routes
- Improve cycle routes
- Introduce taxi schemes
- Provide car park management
- Improve community transport provision (including voluntary driver/car schemes)
- Link timing and booking of NHS services with public transport provision
- Roadside improvements at NHS sites, eg bus shelters, lower pavements at transport interchanges
- Information provision and promotion of NHS transport, public transport, walking and cycling routes
- Provide reduced-fare schemes.

## *Partnerships and funding for accessibility*

The main mechanisms for developing joint work are:

- Local authority transport and NHS partnerships
- Working groups at key NHS sites, eg hospital travel planning groups
- Project-based partnerships to manage funds used for transport and health access projects such as Rural Bus Challenge and Invest to Save.

The main funding sources have been:

- Urban and Rural Bus Challenge schemes with financial support from NHS trusts
- Invest to Save programme funding to pilot integrated specialist transport services
- Rural transport partnership funding
- Negotiating concessionary fares with operators
- PCTs commissioning community transport services
- Local authority funding of new public transport/ community transport services, eg using section 106 agreements
- Countryside Agency funding for improving access in rural areas.

## *Monitoring and evaluation of NHS action on accessibility*

Local practice provides the following examples of measures of change. Some focus on process, others on activity:

- Introduction of travel plans (to achieve change in modal split of patients and staff)
- Introduction of new bus services and use of new hospital bus routes
- Improved transport waiting facilities (including new public transport shelters)
- New vehicles
- Increased frequency of bus services on core routes
- New or improved information marketing and publicity for transport services and walking and cycling routes
- Improved cycle parking
- Reduction in car trips between NHS sites
- Patronage of specialist bus services operating between NHS sites

- Reduction/redistribution in the number of car parking spaces
- Improvements in cycle and walking routes to NHS sites
- Number of trips of voluntary car schemes
- Customer satisfaction with voluntary car schemes
- Number of beds unblocked as a result of providing transport home for patients in hospital
- Membership of demand-responsive transport scheme
- Changes in use of patient transport services as a result of broadening eligibility criteria for these services
- Reduction in the number of patients attending a GP surgery rather than a mobile health unit from targeted areas
- Number of passenger journeys to health facilities and reduction in numbers of 'did not attends'.

## Examples of local practice

Recent years have seen various pilot projects and experiments, funded from a variety of sources, addressing particular issues in transport to health. This section outlines a number of these schemes, their aims, expectations and outcomes.

The common thread running through most of the patient- and visitor-based schemes is patients' difficulties in accessing health services due to geographical isolation or mobility difficulties and inability to use existing public transport.

A key element of several other schemes is meeting the transport needs of hospital staff, either for the journey to work or during the course of their work. Each scheme is evaluated against key criteria in a summary table.

### Key lessons

The key lessons to emerge are the need for:

- Coordinated local research to understand the transport access needs of key groups
- A focus on reducing the need to travel (especially by car) to NHS sites as well as improving access through sustainable means
- Effective local transport and health partnerships with senior backing and identified contacts with whom to work
- Joint commissioning of transport services to the NHS, linked to the broader integration of public and specialist transport services in the area
- Development of local indicators and targets in order to track improvements in access to services for key groups or areas.

### *Stratton Mobile Health Unit, Cornwall*

This is a mobile surgery serving 4,500 patients in villages in the area around Bude in Cornwall. It takes mobile surgery facilities out into the villages, and during the summer months also provides a minor ailments and injuries unit for holiday-makers in Bude, located in the town centre car park in the mornings.

The unit was jointly funded by the Countryside Agency, Health Action Zone, Cornwall County Council and the Stratton Health Centre.

The vehicle meets Disability Discrimination Act (DDA) requirements and the consulting rooms are soundproofed for privacy. An on-board computer is used to maintain patients' records and print prescriptions. Staffing includes a GP, practice nurse or physiotherapist and a driver/ security person.

The project was introduced in response to the retirement of a local GP and the transfer of his patients to the Stratton Health Centre. The practice had also operated a number of outreach surgeries in several villages, but these were in unsuitable premises (including a private dwelling) which did not meet the required levels of confidentiality or accessibility.

The unit was very expensive to purchase, costing over £100k. The practice had to work with the manufacturer to develop a prototype.

Around 95% of the available appointment slots are booked. The summer clinic has been especially useful in reducing the requirements for emergency appointments at the health centre, and averages over 150 patients a week. The practice has employed a locum to staff these clinics, freeing time for the practice GPs.

| Project title | Stratton Mobile Health Unit |
|---|---|
| **Geographical area** | Bude, Cornwall |
| **Target group** | Village residents, holiday-makers |
| **Setting** | Rural coastal area |
| **Type of project** | Mobile health centre |
| **Focus of intervention** | Mobile health service provision for population of 4,500 patients, prompted by the retirement of a village GP and difficulties in making part-time rural surgeries DDA-compliant |
| **Aims and objectives** | To reduce the need for patient travel to surgeries and provide an outreach clinic for summer visitors |
| **Intervention methodology** | Fully staffed, DDA-compliant vehicle fitted out as mobile GP surgery. 50 appointments per week available for local residents |
| **Evaluation strategy** | A small survey of users was conducted. The number of summer visitors using the service averaged 185 a week |
| **Situation analysis** | Mobile surgery has been particularly useful to those with mobility problems. Summer surgery has been used by a wider cross-section of the community |
| **Outcomes** | Significant improvement in accessible surgery facilities and reduction of summer visitors using the health centre. Summer visitor centre staffed by a locum, freeing the practice GPs |
| **Success indicators** | Appointment slots almost always fully booked |
| **Learning points** | Vehicle registration and insurance issues delayed introduction of the scheme. Much work was needed in designing the prototype vehicle. The vehicle has high capital cost, so replacement will be a major issue |
| **Evidence for incorporation in mainstream delivery** | Part-time surgeries have been closed, use of the mobile unit continues |
| **Funding agencies** | Joint funding by Countryside Agency, Health Action Zone, Cornwall County Council and Stratton Healthcare Trust |
| **Cost of intervention** | Capital cost £105k, day-to-day running costs paid by Countryside Agency (£13k per year) |
| **Contact details** | Jenny Keane, Practice Manager, Stratton Medical Centre, Hospital Road, Stratton, Bude EX23 9BP<br>Tel: 01288 352133; email: jenny.keane@strattonmed.cornwall.nhs.uk |

### *Cambridge University Hospitals NHS Foundation Trust – Addenbrooke's Shuttle Bus*

Addenbrooke's Hospital is a large primary care facility on the edge of Cambridge. Limited parking space and associated congestion have led the Trust to institute a number of sustainable transport developments aimed at reducing dependence on the car by encouraging use of alternative modes. Bus use has been boosted by the building of a hospital bus station on the site of one of the hospital car parks. The Trust worked closely with Stagecoach when it revamped its network with 'Citi' branding, which saw a large increase in the frequency of buses serving the site and also a major simplification of the route pattern.

However, the Trust acknowledged the need for additional facilities for those travelling to the hospital by car. Cambridge has a number of established park-and-ride sites, and the site at Trumpington is a short journey from the hospital. The Trust commissioned a park-and-ride service linking the Trumpington park-and-ride site with the hospital. Initially this used the original operator's own vehicles in standard livery.

In 2004 the decision was made to raise the profile of the service. The Trust leased two new low-floor minibuses in a special livery and issued new tenders for an improved service. This started in July 2004. It is not a free service, with fares charged at a commercial rate, but discounted 10-trip tickets are available for hospital workers.

This is a highly unusual step of a hospital specifying, funding and putting out to contract its own bus service. Conventionally, any local bus contract would be handled by the local authority.

| Project title | Addenbrooke's Shuttle Bus |
|---|---|
| **Geographical area** | Cambridge |
| **Target group** | Hospital workers, patients and visitors |
| **Setting** | Out-of-town hospital site |
| **Type of project** | Park-and-ride service |
| **Focus of intervention** | Development of a park-and-ride service linking the hospital to an established park-and-ride site |
| **Aims and objectives** | To reduce the level of car movements to and from hospital and reduce pressure on parking spaces |
| **Intervention methodology** | Lease of two new vehicles commissioned by Hospital Trust |
| **Evaluation strategy** | Monitoring of passenger use and mode of travel to the hospital |
| **Situation analysis** | Addenbrooke's is a large hospital site with severe parking limitations. Major steps have been taken to encourage the use of sustainable modes of transport |
| **Outcomes** | Coupled with other initiatives, the percentage of staff using cars to get to work has reduced to 40% from 70% in 10 years |
| **Success indicators** | Not known – the scheme is in the first year of operation in its new form |
| **Learning points** | A high-profile service with branded vehicles and promotion within hospital literature are seen as vital for growing traffic on the service. Security at the park-and-ride site is also important. It is unusual for bus service contracts to be handled by an NHS trust – this shows it is possible |
| **Evidence for incorporation in mainstream delivery** | Development of a service previously operated by a bus company using its own vehicles |
| **Funding agencies** | Hospital Trust and passenger revenue |
| **Cost of intervention** | In excess of £100k |
| **Contact details** | Dr Wyn Hughes, Service Development Manager for Estates and Facilities, Addenbrooke's Hospital, Hills Road, Cambridge CB2 2QQ<br>Tel: 01225 245151; email: wyn.hughes@addenbrookes.nhs.uk |

### *Weald School/Transport to Hospital Scheme*

The East Surrey Rural Transport Partnership designed this scheme within the district of Tandridge to provide:

- School transport service to Weald Primary School for pupils in rural villages
- Transport for home assessments for the Intermediate Care Team at East Surrey Hospital
- Transport to East Surrey Hospital for patients and visitors living in remote parts of the East Surrey PCT area, who are not entitled to hospital transport but would find it difficult to get to their appointment without transport support.

The above was actioned through the introduction of a minibus-based transport scheme. Primary school pupils were not entitled to school transport and were largely being taken to school individually in private cars. The alternative walking route to school had been identified as unsuitable by the Safer Routes to School team.

The intermediate care team had had problems with transport for patients being released from hospital: usually the patient and staff member travelled in separate vehicles to make home assessments and put the appropriate equipment in place. These arrangements often raised health and safety issues. In addition, the transport of hospital staff for home assessments and visits normally used valuable ambulance service resources.

The vehicle has been used principally for trips originating at the hospital. Availability for trips to hospital appointments was limited. Transport of patients attending a day-care centre has now been added to the vehicle's regular work.

Trips to the hospital can now be made on the demand-responsive 'Buses4U' service introduced subsequently with Rural Bus Challenge funding.

| Project title | Weald School/Transport 2 Hospital Scheme |
|---|---|
| **Geographical area** | East Surrey |
| **Target group** | Hospital patients and non-statutory schoolchildren |
| **Setting** | Affluent rural area |
| **Type of project** | Minibus-based patient transport scheme |
| **Focus of intervention** | Provision of a minibus to replace use of private transport, ambulances and taxis |
| **Aims and objectives** | To provide transport for patients discharged from East Surrey Hospital; for hospital staff making home visits; and to the Weald School |
| **Intervention methodology** | Scheme coordinated by East Surrey Rural Transport Partnership to bring together different transport needs. School service operates at fixed times; Intermediate Care Team book vehicle in advance for morning visits; Hospital Transport Manager books homeward journeys for discharged patients. Vehicle otherwise available for booking for hospital appointments or visits |
| **Evaluation strategy** | Not known |
| **Situation analysis** | Previous problems with multi-vehicle trips for patients being discharged, with use of taxis commonplace. Most pupils at Weald School were being taken individually in private cars |
| **Outcomes** | The 'Buses4U' Rural Bus Challenge-funded project has subsequently been introduced, providing a demand-responsive service within Tandridge between 09:00 and 23:00 (except afternoon school times). The hospital minibus now provides transport for a day centre in Reigate |
| **Success indicators** | Incorporation of additional routes suggests that the vehicle has become established |
| **Learning points** | The Intermediate Care Team had previously spent around £1,000 per month on home visits using ambulances and taxis. The volume of work from the health service has meant that availability of the vehicle for other trips is limited and unpredictable |
| **Evidence for incorporation in mainstream delivery** | Additional routes have been incorporated into the vehicle's operations |
| **Funding agencies** | Local transport plan funding for vehicle costs through Surrey County Council Safe Routes to School team. Operating costs supported by Surrey County Council (Passenger Transport Group and Tandridge Local Committee), East Surrey PCT, Tandridge District Council, Redhill Hospital Intermediate Care Team, plus revenue from schoolchildren |
| **Cost of intervention** | Not known |
| **Contact details** | East Surrey Rural Transport Partnership, Tandridge District Council, Council Offices, Station Road East, Oxted RH8 0BT. Tel: 01883 732791; email: rtp@tandridge.gov.uk |

## *Joint funding of Wiltshire Link schemes*

Wiltshire has the most comprehensive coverage of any county by good-neighbour car schemes. Most schemes are parish-based and cater for needs within a particular local area. These have been coordinated under a generic title as Link schemes. Link schemes are not focused wholly on health trips – they were set up to offer a range of journeys to allow isolated residents access to facilities, but approximately 50% of their journeys are health-related.

There are some problems as the demand for health-related trips makes it more difficult for the LINK scheme to cater for other socially important journeys.

Prior to establishment of the joint funding partnership, each scheme had to apply in its own right for funding from several bodies. The Funding Partnership was established in 1997 to coordinate grants from three key partners: Wiltshire County Council Passenger Transport Unit; Wiltshire County Council Social Services Department; and Wiltshire Health Authority. The partnership is hosted by Community First (Wiltshire Rural Community Council). A successful bid for Lottery funding financed the employment of a Link development officer. The partnership has been expanded to include local PCTs and district councils. Annual grant funding now totals around £46k per annum.

| Project title | Wiltshire Link schemes |
|---|---|
| **Geographical area** | Wiltshire and Swindon |
| **Target group** | Older people, disabled and socially isolated |
| **Setting** | Mainly rural areas |
| **Type of project** | Voluntary car schemes |
| **Focus of intervention** | Coordination of several existing and some new parish-based car schemes providing voluntary transport |
| **Aims and objectives** | To provide journey opportunities to health facilities, shopping and leisure pursuits for those without their own means of transport |
| **Intervention methodology** | Coordinating different schemes under the Link umbrella and bringing together different funding schemes. Appointment of Link development officer |
| **Evaluation strategy** | Data collected on all trips and journey purposes |
| **Situation analysis** | Forty different Link schemes operate within Wiltshire. All are provided and staffed on a voluntary basis. Community First (Wiltshire Rural Community Council) acts as coordinator, but each scheme operates independently and has its own contact number |
| **Outcomes** | There has been an increase in the schemes in recent years and increased demands on the service |
| **Learning points** | The proportion of health-related trips has dominated most schemes (average 50% of all journeys) and has sometimes made provision of journeys for other reasons difficult |
| **Evidence for incorporation in mainstream delivery** | Wiltshire County Council includes details of Link schemes within its general public transport information. The Link partnership has been in existence for eight years |
| **Funding agencies** | Initially Wiltshire County Council (Passenger Transport Unit and Social Services Department), Wiltshire Health Authority. Now includes district councils and PCTs |
| **Cost of intervention** | £46k per annum. Lottery funding for appointment of development officer |
| **Contact details** | Liam Tatton-Bennett, Community Transport Project Officer, Community First, Wyndhams, St Joseph's Place, Devizes SN10 1DD<br>Tel: 01380 722745; email: ltatton-bennett@communityfirst.org.uk |

## *Royal United Hopper , Wiltshire*

The catchment area of the Royal United Hospital at Bath includes a large area of western Wiltshire. Those without their own transport found it very difficult to get to the hospital, often involving three separate journeys. As a result there was a reliance on lifts from friends and relatives, and increased demand for the Link car schemes.

This is a demand-responsive minibus service funded by the DfT Rural Bus Challenge (£453,000). The service provides direct access to the Royal United Hospital from western Wiltshire for patients, staff and visitors. Eight fully accessible minibuses are employed on the service, which is run on a pre-bookable basis requiring 48 hours' notice prior to a trip. There are hourly departures from the Royal United Hospital up to 17:30.

The service was much more costly than anticipated. The County Council had assumed a local taxi operator would be the successful bidder and would have its own booking line and system set up. As it was, there was some difficulty obtaining a suitable contractor and in the end a minibus operator situated some distance from Bath bid successfully, but then had to set up a booking system.

The service undertakes around 1,200 passenger trips per month at a trip subsidy cost of £6–7 per passenger journey. The cost of operating the service has increased in line with the increase in passenger trips as the contract is funded on a mileage basis. The service is used primarily by older people attending out-patient appointments. Few staff use the service as it does not cater for shift working and the need to pre-book discourages impromptu visits and regular passengers.

Partners in setting up the service were Wiltshire County Council Passenger Transport Unit, West and North Wiltshire District Councils, Royal United Hospitals. The project is managed by Parkman Ltd (consultants).

In 2004 the original challenge funding expired and a bid for further funding was unsuccessful. The service is now funded primarily by Wiltshire County Council with contributions from some health trusts.

| Project title | Royal United Hopper |
|---|---|
| **Geographical area** | West Wiltshire |
| **Target group** | Hospital staff, visitors and outpatients |
| **Setting** | Rural area |
| **Type of project** | Demand-responsive minibuses |
| **Focus of intervention** | Demand-responsive minibus service providing an hourly service to and from the Royal United Hospital |
| **Aims and objectives** | To provide single-leg journeys from rural areas of western Wiltshire to the Royal United Hospital at Bath for those with social rather than medical needs, within an hour's journey time |
| **Intervention methodology** | Eight fully accessible minibuses provide a pre-booked, fully demand-responsive service over a wide area. The booking system and scheduling are administered by the operator |
| **Evaluation strategy** | Passenger numbers and mileage are monitored continuously and periodic user surveys have been carried out |
| **Situation analysis** | Public transport journeys to Royal United Hospital from western Wiltshire were lengthy and awkward. Areas with a limited bus service often could not fit around appointment times. The service is used primarily by older people (66% of users aged over 60) and 91% of trips are for outpatient appointments. Levels of use have stabilised at around 1,200 passengers a month |
| **Outcomes** | A significant improvement in accessibility to the Royal United Hospital. Concessionary fares are available on the service which adds further benefit for those eligible. The hospital has been proactive in arranging appointments to suit available journey times |
| **Success indicators** | 1,200 passengers a month, 59% of whom would have travelled by car. Also, possibly reduced pressure on Link schemes for provision of health-related trips |
| **Learning points** | Difficulty in finding an operator willing to take on the operation. Uncertain levels of subsidy as operator is paid per mile operated. Some conflict with Link schemes providing similar trips. Long booking period can inhibit trip-making. Uncertain working relationship with the Hospital Trust |
| **Evidence for incorporation in mainstream delivery** | Original challenge funding ran out in 2004 and the service has continued under a revenue support arrangement |
| **Funding agencies** | Initially Rural Bus Challenge. Now Wiltshire County Council, District Council and Health Trusts |
| **Cost of intervention** | £100k per annum |
| **Contact details** | Ian White, Wiltshire County Council, Environmental Services Department, County Hall, Trowbridge BA14 8JD<br>Tel: 01225 713322; email: ianwhite@wiltshire.gov.uk |

### *Making better use of the fleet – East Midlands Ambulance Service and Nottinghamshire County Council*

Nottinghamshire County Council's Best Value Review identified that social services vehicles were not being used as effectively as they might be, as the service demand for vehicles was low between 11:30 and 14:30. At the same time, East Midlands Ambulance Service was under extreme pressure to improve services to non-emergency patients.

In 2000, Nottinghamshire County Council entered into a contract with East Midlands Ambulance Service to provide social services vehicles and drivers for non-emergency patient transport during their downtime period. The benefits of this arrangement have been:

- Improved services for patients
- Additional turnover for Nottinghamshire County Council of £78,000 per annum, and money savings for the ambulance service
- Increased recruitment of part-time drivers.

The scheme has been extended and Nottinghamshire County Council now also takes patients home from hospital between 18:00 and 20:30.

| Project title | East Midlands Ambulance Service and Nottinghamshire County Council Fleet Use Review |
|---|---|
| **Geographical area** | Nottingham |
| **Target group** | Hospital patients |
| **Setting** | City Hospital |
| **Type of project** | Vehicle coordination scheme |
| **Focus of intervention** | Coordination of vehicle provision between social services and non-emergency patient transport |
| **Aims and objectives** | To maximise the efficient use of vehicles and crews employed by both agencies |
| **Intervention methodology** | Examining times of peak use of vehicles and following up Best Value Review recommendations to achieve optimum use of resources |
| **Evaluation strategy** | Monitoring use of resources |
| **Situation analysis** | Social services vehicles peaked in the morning and late afternoon but were under-used at other times. Ambulance service vehicle requirements peaked in the middle of the day |
| **Outcomes** | Social services vehicles now run under contract to the ambulance service, providing additional income for social services and cost savings for the ambulance service |
| **Success indicators** | Reduced waiting times for patient transport |
| **Learning points** | Potential expansion to other areas on similar principles. Recruitment of part-time drivers eased additional staffing requirements. Has avoided complexity of all journeys as ambulance service retains responsibility for arranging transport |
| **Evidence for incorporation in mainstream delivery** | Use of social services vehicles has now been extended into the evenings for transporting patients home |
| **Funding agencies** | None |
| **Cost of intervention** | Self financing. £78k per annum additional income for social services |
| **Contact details** | David Gibbons, Transport and Services Division, Social Services Department, Nottinghamshire County Council, 2 Riverside Way, The Meadows, Nottingham NG2 1D Tel: 0115 986 2211; email: david.gibbons@nottscc.gov.uk |

### *Holme Valley Patient Transport Scheme – reducing home visits and improving patient care*

Three GP practices in the Holme Valley in West Yorkshire worked together to provide a patient transport scheme, providing free travel to the surgery for patients who are well enough to travel but are unable to get to the surgery. The aims of the project were to reduce the levels of home visits by health centre staff and to enable more patients to be seen in a clinical setting.

The scheme provides lifts for 100 patients a week from a 30-square-mile area. The surgeries estimate they have reduced the number of home visits from around 150 to 40 per week.

Attendance at chronic disease clinics has also increased since the introduction of the service. More patients are being seen in a clinical setting.

Initial funding for the project came from the Countryside Agency. After expiry of the initial funding, the practices received short-term cash support from Huddersfield PCT. The service costs around £30,000 a year to run. The practices now fund the service themselves under practice-based commissioning arrangements.

| Project title | Holme Valley Patient Transport Scheme |
|---|---|
| **Geographical area** | Kirklees, West Yorkshire |
| **Target group** | Patients at GP surgeries |
| **Setting** | Rural |
| **Type of project** | Car scheme |
| **Focus of intervention** | Provision of patient transport from 12 rural villages to three GP practices in the Holme Valley |
| **Aims and objectives** | To aid access to GP surgeries for older people and the isolated. Reduce the number of home visits by GPs and nursing staff |
| **Intervention methodology** | Provision of bookable multi-purpose vehicle for transport to and from appointments |
| **Evaluation strategy** | Assessment of home visits by GPs and district nurses |
| **Situation analysis** | GPs were frequently called out to home visits due to patients being unable to reach the surgery. Patients in rural areas also had difficulty attending clinics such as those for chronic disease and podiatry |
| **Outcomes** | Reduction in the level of GP call-outs and home visits by district nurses. Improved access to health centre facilities by patients |
| **Success indicators** | Carrying about 100 passengers per week. GP home visits reduced from 150 to 40 per week. Attendance at chronic disease clinics has increased |
| **Learning points** | More patients can be seen in a clinical setting. After the initial phase, the costs of the service must be borne by the practices |
| **Evidence for incorporation in mainstream delivery** | The service has continued under Practice Based Commissioning |
| **Funding agencies** | Initially Countryside Agency, then PCT provided bridge funding, now continued by the practices. Some fund-holding savings[1] |
| **Cost of intervention** | £27,000 operating cost per year |
| **Contact details** | Duncan Miller, Practice Manager, Elmwood Health Centre, Huddersfield Road, Holmfirth HD9 3TR<br>Tel: 01484 689111; email: Duncan.millar@gp-b85610.nhs.uk |

[1]The cost of a home visit has been estimated at £15 for a GP and £12 for a practice nurse (Centre for Innovation in Primary Care, December 1999)

## *Amber Valley Transport for Health*

This scheme was set up using Rural Bus Challenge funding in an area north of the City of Derby. The service aimed (like the Weald scheme, page 7) to provide safe, secure transport home for patients being discharged. One of the driving forces behind the scheme was the threat of litigation against occupational therapists if they could be seen to have placed patients at risk during the journey home.

The Amber Valley scheme initially used an existing vehicle from a community transport organisation which was then reimbursed on a rate-per-hour basis. This led to some problems if the community transport vehicle had been pre-booked by another group or organisation, and limited its use by hospitals. The second allocation of Rural Bus Challenge funding allowed the purchase of a new bespoke vehicle dedicated to the patient service.

| Project title | Amber Valley Transport for Health |
|---|---|
| **Geographical area** | North Derbyshire |
| **Target group** | Patients being discharged and occupational therapists |
| **Setting** | Urban and suburban |
| **Type of project** | Minibus scheme |
| **Focus of intervention** | Provision of safe, secure transport |
| **Aims and objectives** | To provide accessible, secure transport home for patients following discharge from hospital |
| **Intervention methodology** | Use of community transport minibus and drivers to replace previous arrangements with cars, ambulances and taxis |
| **Evaluation strategy** | Informal information gathering |
| **Situation analysis** | Previously patients and occupational therapists travelled in separate vehicles. Occupational therapists were previously exposed to the threat of litigation if patients were endangered during the journey. Originally the community transport organisation provided an existing vehicle and charged the Trust on an hourly basis for use of the vehicle |
| **Outcomes** | Used by 948 passengers in nine months, 96 of whom were wheelchair users |
| **Success indicators** | Reduced travel time and cost and removed the need for staff transport. Good partnership working |
| **Learning points** | Some lack of coordination between hospitals requiring the vehicle. Bookings by regular groups have limited availability to hospitals at times |
| **Evidence for incorporation in mainstream delivery** | Second tranche of funding has led to the purchase of a bespoke vehicle devoted to the work |
| **Funding agencies** | Rural Bus Challenge (two awards), Amber Valley PCT |
| **Cost of intervention** | £60k capital cost, £32.7k annual running cost, £4,500 annual revenue |
| **Contact details** | Elaine Wachlarz, Derbyshire County Council, Passenger Transport Unit, Environmental Services, County Hall, Matlock DE4 3AG<br>Tel: 01629 585743; email: elaine.wachlarz@derbyshire.gov.uk |

### *Gloucester Hospital Transport Scheme*

This scheme focused on the travel requirements of those with a medical or social need for transport to healthcare from a rural area. The aim was to coordinate the transport activities of the Gloucestershire Ambulance Service and volunteer groups.

Many of the journeys provided by the ambulance service had used volunteer drivers. The core of the project was the transfer of these resources from the ambulance service to the voluntary sector. Funding was provided for a new IT system to handle bookings for trips and act as a central point for GP surgeries and other health agencies to contact for transport arrangements.

For users of the system there was a disparity in their contribution to costs – the ambulance service did not charge for transport, but the voluntary service charged journeys at 37 pence per mile.

The main problems in setting up the new arrangements lay in identifying who had responsibility for transport arrangements, particularly in larger hospitals. Often health service professionals did not attach a high priority to transport issues. There was also much resistance to change.

An ongoing problem was the lack of a contact point for drivers working out of hours. The booking system was live only during office hours. This also means that hospital staff have no point of contact if they need to arrange transport during these times.

| Project title | Gloucester Hospital Transport Scheme |
|---|---|
| **Geographical area** | South Cotswold District, Gloucestershire |
| **Target group** | Patients with medical or social need for transport to healthcare |
| **Setting** | Rural |
| **Type of project** | Vehicle and Driver Coordination Scheme |
| **Focus of intervention** | Coordination of non-emergency patient transport services and volunteer services resources |
| **Aims and objectives** | To optimise service delivery through best use of resources |
| **Intervention methodology** | Coordinated booking and scheduling of journeys at one centre using new IT system. Responsibility for non-emergency patient transport services has transferred from the Ambulance Service to the voluntary sector (Gloucester Centre for Voluntary Services, GCVS) |
| **Evaluation strategy** | Data on all journeys and mileage collected |
| **Situation analysis** | Gloucestershire Ambulance Service and GCVS had previously operated independently, with duplication of resources and delays for some patients leaving hospital. The Department for Transport funded external consultants to progress this as a pilot exercise |
| **Outcomes** | Trips operated by GCVS up about 300%, with a similar reduction for Gloucestershire Ambulance Service. Percentage of dead mileage reduced from 60 to 30% |
| **Success indicators** | Simplified access to booking arrangements for GP surgeries. More responsive service for patients |
| **Learning points** | Disparity between charges for GCVS cars (37 pence per mile) and free ambulance transport. Consultation process was lengthy and onerous. Experience of resistance to change and low prioritisation of transport issues. Very difficult to establish identity of, and liaise with, appropriate person in larger hospitals. No communications for drivers and hospital staff outside office hours |
| **Evidence for incorporation in mainstream delivery** | Arrangement is ongoing |
| **Funding agencies** | Some DfT funding, otherwise internal/local |
| **Cost of intervention** | Gloucestershire Ambulance Service considers this ‘sensitive’ |
| **Contact details** | Mike Flute, Gloucestershire Ambulance Service NHS Trust, Gloucestershire TriService Centre, Waterwells Drive, Waterwells Business Park, Quedgeley, Gloucestershire GL2 2BA Tel: 01452 753030; email: mike.flute@glosamb.swest.nhs.uk |

## *East Durham Hospital Link*

This scheme originated from a need identified by those with mobility difficulties in accessing Hartlepool General Hospital at visiting times. An existing community transport operator in Easington had received requests for such journeys but could not provide them within its existing budget.

Funding from Rural Bus Challenge and the Countryside Agency was used to start up the service, which provides trips on demand for afternoon and evening visiting times, using a fully accessible minibus.

This service is aimed wholly at visitors rather than patients, and a community transport operator is used rather than volunteer car services, social service vehicles or ambulance service transport. There is evidence that the health of patients who receive visitors improves more rapidly and can lead to earlier discharge from hospital.

| Project title | East Durham Hospital Link |
|---|---|
| **Geographical area** | Easington, County Durham |
| **Target group** | Hospital visitors |
| **Setting** | Former mining communities |
| **Type of project** | Demand-responsive minibus |
| **Focus of intervention** | Providing accessible transport for older and disabled visitors to Hartlepool General Hospital |
| **Aims and objectives** | To improve access to Hartlepool General Hospital at visiting times |
| **Intervention methodology** | Use of existing, fully accessible minibus in partnership with a community transport operator |
| **Evaluation strategy** | Data on numbers and origins of trips should be supplied by the operator as part of the service level agreement |
| **Situation analysis** | The less mobile had difficulty getting to the hospital by conventional public transport, particularly in the evenings. The community transport operator had identified a demand for a service at visiting hours but did not have the resources to fulfil the requests |
| **Outcomes** | Evidence has shown that patients' health improves more rapidly if they receive visitors. This will help improve the rate of turnover of patients |
| **Success indicators** | Data from operator still pending |
| **Learning points** | Experimental use of community transport operator where volunteer cars, social service vehicles and local ambulance service have traditionally been used in other areas. Keen and willing operator, but difficult to obtain information |
| **Evidence for incorporation in mainstream delivery** | Pilot period still ongoing |
| **Funding agencies** | Rural Bus Challenge, Countryside Agency |
| **Cost of intervention** | Running costs £24k per annum |
| **Contact details** | Stephen Metcalfe, East Durham Rural Transport Partnership Officer, Durham County Council, Public Transport Group, Environment Department, County Hall, Durham DH1 5UQ Tel: 0191 3833394 |

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