

going places

taking people to and from education,
social services and healthcare

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going places

1



Background

Local authorities and health bodies provide transport for people to travel to education, social services and hospitals, at an overall cost of about £900 million a year.

2



Using the Services

Service users include some of the most vulnerable members of society; including children with special needs and elderly and sick people. Their experiences reveal significant variations in service quality and service standards across England and Wales.

3



Delivering the Services

Service managers need to consider other policy areas, including social inclusion and the environmental agenda, when delivering services. They will also need to make trade-offs between costs and service quality.

4



The Way Forward

Ensuring fair access and equitable transport services requires action from central government and from local authorities and NHS bodies.

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Preface



The Audit Commission has been examining transport arrangements made by local authorities and health bodies in England and Wales to take people to education, social services and hospitals. The work has focused on home-to-school transport, social services transport and non-emergency patient transport in the National Health Service.

The Audit Commission has previously reported upon home-to-school transport in *Home-to-School Transport: A System at the Cross Roads* (Ref. 1), which it published in 1991. It has not previously carried out a national study into social services transport or non-emergency patient transport (though it has examined emergency ambulance services in the NHS, in its 1998 report *A Life in the Fast Lane* (Ref. 2)).

This report, *Going Places*, sets out the Commission's overall findings. It contains recommendations for action by central government and by local government and the health service. As the Department for Education and Skills (DfES) has been examining travel support arrangements for students above the statutory school age (that is, who are aged 16 and over) the Commission's work on transport to education focuses particularly on travel by pupils aged under 16.

In addition to this overall report, the Commission is also to issue four separate handbooks focusing in more detail on the management and operational aspects of transport provision for: home-to-school transport for children with special educational needs; mainstream home-to-school transport; social services transport; and non-emergency patient transport. Each handbook contains examples of good practice together with self-assessment checklists. These handbooks (Refs. 3-6) can be used by local authority officers and those in the health service who set local policies and who arrange, manage and provide transport.

Going Places draws upon:

- field visits to ten local authorities (listed at Appendix 1). The study team interviewed officers; examined documents; visited schools and social services centres; and spoke to headteachers, pupils, social services staff and clients, and to drivers and passenger assistants (escorts)¹. The team also travelled on vehicles that were taking children to and from school and social services clients to and from day centres. On some visits, the team met contractors who were providing the transport, and providers of community and voluntary transport;

¹ Passenger assistants are employed to travel on vehicles to help and supervise passengers. They are also sometimes referred to as escorts. However, 'escort' has a different meaning, in the NHS where it means someone – a member of the patient's family or a friend – who voluntarily accompanies the patient.

- field visits to eight ambulance services and to 12 commissioning trusts (also listed at Appendix 1). The study team interviewed officers and staff in ambulance services; and also interviewed staff at hospital trusts, including some clinicians; met volunteer drivers; spoke to patients and travelled on vehicles;
- discussions with focus groups of service users and their carers or parents (see Appendix 2)^I;
- findings from best value inspections carried out by the Audit Commission's Best Value Inspection Service; findings from inspections of local education authorities (LEAs) carried out by OFSTED with the Audit Commission, and reviews of social services authorities carried out jointly by the Social Services Inspectorate (SSI) and the Audit Commission;
- work on home-to-school transport for children with special educational needs carried out in London by the Commission's auditors in 1999 and 2000^{II} and work by the Commission's auditors with individual ambulance service trusts and hospital trusts;
- desk research and analysis. This included examining OFSTED and Estyn reports on individual schools in authorities visited by the Commission's project team and SSI reports on those authorities. The project team also analysed data provided by Government departments and the National Assembly for Wales and by OFSTED. The Patient Transport Committee of the Ambulance Services Association (ASA) kindly provided anonymised data from a survey of its members; and
- advice issued earlier this year (2001) by the then Department for Education and Employment (DfEE) (Ref. 8) and research by the then Department of the Environment, Transport and the Regions (DETR) (Ref. 9).

Home-to-school transport, social services transport and non-emergency patient transport improve access to public services. They promote social inclusion and help to address environmental concerns about growing car use. Their users include some of the most vulnerable people in society.

I Unless specifically indicated otherwise, quotes from users and others used in this report are from these focus groups or from interviews carried out by the Commission during its research.

II The Commission also followed up this work with a questionnaire survey in London in 2000. The Commission reported on this in March 2001 in its report, *The Special School Run* (Ref. 7).

Local authorities have already done much to provide good home-to-school transport and social services transport but there are opportunities to improve these services and their user focus still further. There are also many examples of good practice in non-emergency patient transport services (PTS) but, here too, there are also opportunities for improvements and, particularly, better patient focus. It is essential to address the need for change. Public services are becoming increasingly user- and patient-focused as they modernise and expectations are likely to rise in response to best value and to *The NHS Plan* (Ref. 10) and *Improving Health in Wales* (the NHS Plan in Wales) (Ref. 11).

The Government can help, by improving the framework within which local authorities and health bodies work. But local government and the NHS can also do much within the current framework by building upon existing good practice.

This report sets out the case for change together with an agenda for action:

- Chapter 1, ‘Background’, summarises the role and purpose of home-to-school transport, social services transport and non-emergency patient transport; who uses each; the costs of the services; and how they are managed, organised and delivered.
- Chapter 2, ‘Using the Services’, focuses on what it is like to use these services.
- Chapter 3, ‘Delivering the Services’, discusses how service delivery interacts with other policy areas, such as the green agenda; the trade-offs between service quality and controlling or reducing expenditure; and how arrangements for managing, organising and delivering the services connect with quality and efficiency.
- Chapter 4, ‘The Way Forward’, sets out action that can be taken by central and local government and by NHS bodies to bring about the improvements needed.

The Commission’s project team – Tim Franklin, Rajesh Kishan and Katharine Knox – was managed by John Gaughan under the overall direction of Greg Birdseye, an Associate Director in the Commission’s Public Services Research Directorate. An independent consultant, Phil Blake, assisted the team with some of the fieldwork and a second consultant, Teresa McGinn, helped with some of the focus groups. An advisory group met the project team regularly throughout the study. Appendix 3 lists the group’s membership.

The Commission is grateful to all who helped, but, as always, responsibility for the contents of this report lies with the Commission.

1



Background

Home-to-school transport, social services transport and non-emergency patient transport enable people to access public services. Expectations are likely to rise in response to best value, *The NHS Plan* and *Improving Health in Wales*.

'I would be devastated if the service stopped.'

Parent (quoted in Best Value Inspection Service report)

'They gave me support when I first lost my sight and I have a remarkably good impression of them [social services transport staff].'

Visually impaired older man

'I am grateful...I don't know what I would do [without the transport].'

Patient

1. Many people use home-to-school transport, social services transport and non-emergency patient transport each year. This chapter discusses:
 - the role and purpose of these transport services;
 - who uses the transport, what the services cost and how heavily they are used; and
 - how they are managed, organised and provided.

'[Without the transport] my daughter wouldn't come to school full stop because I've got three other children.'

Parent of a child with special educational needs

2. These transport services provide people with access to education and social services, and outpatient and other services at NHS hospitals. However, the legal frameworks against which they are provided differ, while the services also contribute to wider policy objectives such as social inclusion, meeting the environmental agenda and ensuring that NHS and local authority resources are used effectively.

Why these transport services are provided

Home-to-school transport

3. A local education authority (LEA) has to provide or arrange *free* transport to and from school for certain pupils of statutory school age, for example, children aged under eight and who live more than two miles from school and older pupils whose homes are more than three miles from school. Entitlement is set out in statute (currently the 1996 Education Act, reproducing many of the requirements of the 1944 Education Act). If the LEA does not provide free travel when it should, the child's parents or guardians are relieved of their obligation to ensure that the child attends school. In addition, the special educational needs *Code of Practice* covers free transport for children who have special needs^I.
4. Councils can also exercise discretion and provide either free or subsidised transport to children who do not have a statutory entitlement and to young people who are above statutory school age who are attending school sixth forms or further education colleges.

Social services transport

5. Local authorities have a duty (under Section 2 of the Chronically Sick and Disabled Persons Act 1970) to provide transport to day services. They may charge service users for this transport but, where they do so, these charges are usually included within the overall charge for the day centre.^{II} About half of authorities charge for social services transport and close to half of these apply a means test (Ref. 14).

Non-emergency patient transport

6. Under NHS guidance, issued in 1991 (Ref. 15), non-emergency patient transport (PTS) *to and from hospital* is provided free of charge when patients have a *medical need*. In contrast, patients can be charged when the transport is provided for *social* reasons. Free non-emergency PTS does not cover travel to general practitioners, dentists or opticians.

I The Department for Education and Skills (DfES) has been consulting on a revised draft of the *Code* during 2001 (Ref. 12). The revised version is expected to come into effect from January 2002.

II The Commission's reports *The Price is Right?* (Ref. 13) and *Charging with Care* (Ref. 14) discuss charges for social services.

Other reasons for providing the transport

‘I couldn’t work properly [as a midwife] without the transport because I’m a single parent. If I had to take her to school I couldn’t do it – the same with collecting her – I couldn’t work.’

Parent of a child with special educational needs

‘[Transport is] a vital lifeline to maintaining independence. Research has shown that a lack of mobility can prevent older people from participating in social activities and lead to low morale, depression and loneliness.’

**Older People; Their Transport Needs and Requirements,
Department of the Environment, Transport and the Regions (Ref. 16)**

7. Poor access to services because of a lack of, or infrequent, public transport, or high transport costs, can be a major factor in social exclusion and rural isolation. Free home-to-school travel, social services transport and free non-emergency patient transport help to overcome these problems. They also bring other benefits. For example:

- Free home-to-school transport can relieve parents of the time commitment involved in taking their children to school, making it easier for them to enter the labour market and to hold down jobs. Women have less access to cars than men and fewer women have driving licences. In single parent families, where women are caring for children, and especially where they are also working, school transport may be particularly important to ensure social inclusion. Women on lower incomes often work part time and taking children to school may be hindered by their working patterns.¹
- Home-to-school transport may also reduce car use by providing an alternative to the ‘school run’. Reducing unnecessary car use is a key part of the Government’s transport and environmental policies. Less traffic congestion at school gates should also improve safety.
- Social services transport can bring isolated and lonely people together for social and other activities. This helps to improve morale and to prevent or reduce depression. Poor morale and depression damage quality of life and can lead to a deterioration in health, which in turn may cause people to place extra demands on social services and the NHS.

¹ *Women and transport: Moving Forward* (Ref. 17) discusses these issues in a Scottish context. Similar issues are likely to arise in England and Wales.

- Some patients might find it difficult to attend hospital appointments if transport did not collect them. Improved attendance should improve the effectiveness of treatments and the efficiency with which the NHS uses resources.
- Where patient transport is provided promptly for patients discharged from hospital, it also helps to ensure that people leave hospital as soon as they are fit to do so, reducing bed blocking. About 24 per cent of NHS acute trusts describe the availability of patient transport as a prime factor, internal to the NHS, in delaying patient discharge (Ref. 18).¹

Usage and cost

Home-to-school transport

8. About half a million children attending mainstream schools receive free home-to-school transport. The proportion of pupils tends to be low in large urban areas, where most children live close to a suitable school, but higher in rural areas, where a greater proportion of children do not live near to their schools. As a result, in England, the percentage of pupils of statutory school age receiving free home-to-school transport tends to be highest in county council areas [EXHIBIT 1].

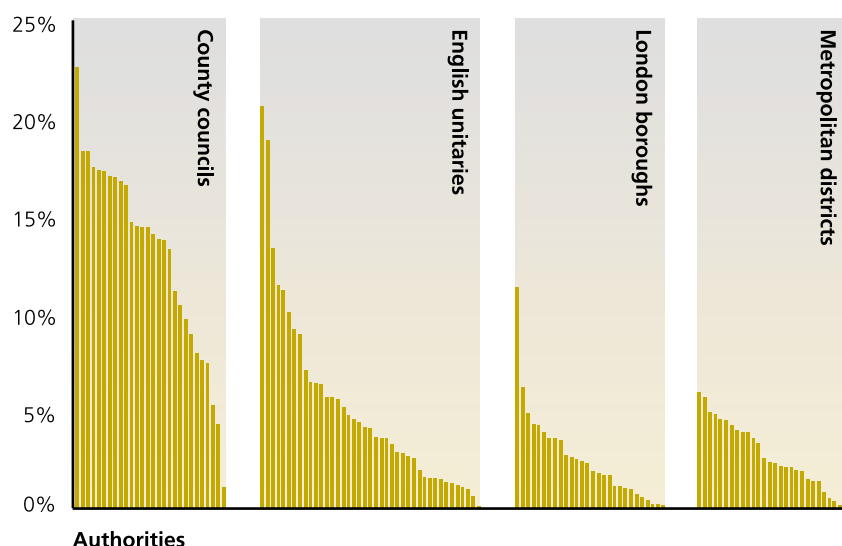
EXHIBIT 1

Mainstream pupils receiving free home-to-school transport

The percentage of pupils travelling free tends to be highest in county councils.

Source: Audit Commission based on data from DfES and Ofsted. Data is for 2000. The equivalent data is not available for Wales.

Percentage of pupils receiving free transport



¹ Ambulance trust staff interviewed by the Commission argue that non-emergency PTS is sometimes available to take people home but is prevented from doing so by delays within hospitals, for example, delays in providing medicines for the patient to take home from the hospital pharmacy.

9. The great majority of pupils attending special schools in England – almost 120,000 children – also receive free transport. This may be on distance grounds but the special educational needs that make attendance at a special school appropriate usually mean that children travelling less than the statutory qualifying distance still require transport to the school. These children have a very wide range of physical disabilities, learning difficulties and behavioural difficulties. They include pupils who attend day schools and those at residential schools, who travel weekly or less frequently. The increasing emphasis on inclusion, where children with special needs attend mainstream schools, means that transport services for children with special educational needs increasingly also cover mainstream schools.

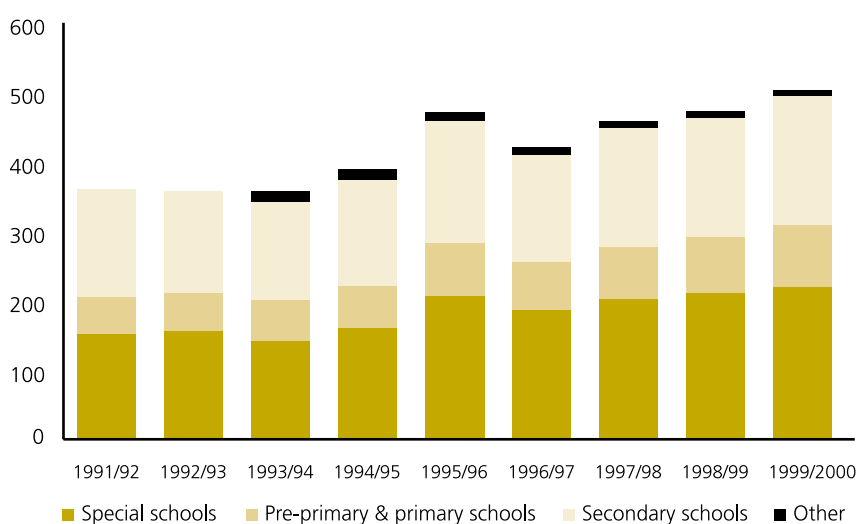
10. In 1999/2000, English LEAs spent about £270 million on home-to-school travel to and from mainstream schools and about £220 million on travel to and from special schools. This expenditure on home-to-school travel by children below statutory school leaving age has steadily increased, from about £360 million (at current prices) in 1991/92 to almost £500 million at the end of the 1990s – a rise of 40 per cent in real terms [EXHIBIT 2]. There is no national data on how the numbers of pupils receiving free travel have changed in that time.¹

EXHIBIT 2

Expenditure by English LEAs on home-to-school transport for pupils below school leaving age

Expenditure rose by about 40 per cent across the 1990s, to nearly £500 million a year by 1999/2000. Travel to special schools accounts for almost half of this.

£million (at 2000/01 prices)



Source: Audit Commission analysis of DfES data

¹ OFSTED has only recently begun to collect data on the numbers receiving free transport. There is no equivalent centrally collected data for Wales.

11. Most (75 per cent) of the mainstream school transport expenditure is by counties. Expenditure varies, but most LEAs spend between £1 and £5 per pupil carried per school day [EXHIBIT 3]. Counties' unit costs per pupil carried tend to be lower than in unitary authorities, London boroughs and metropolitan areas.

12. It is substantially more costly, on average, to provide free transport for a pupil attending a special school than for one attending a mainstream school. Apart from the greater distances travelled, the children usually need a door-to-door service. Some may also need to travel in adapted minibuses or other specialist vehicles – for example, children who use wheelchairs – and most require escorting while they travel. Unit costs are, therefore, higher. Unit costs vary but most LEAs spend between £5 and £15 per pupil carried per school day [EXHIBIT 4]. On average, English counties spent approaching £10 per pupil carried per school day while London boroughs spent over £15.

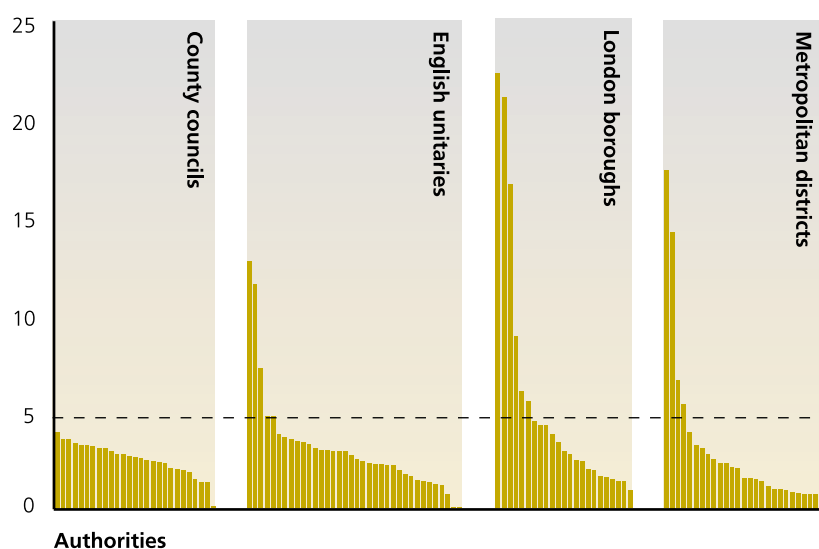
EXHIBIT 3

Average expenditure per pupil carried per school day on mainstream transport in England in 1999/2000

Expenditure varies, but most LEAs spend between one and five pounds per pupil per school day.

Source: Audit Commission based on data from the DfES and OFSTED. Graph is based on total LEA pupil numbers receiving free transport in 1999/2000 (excluding pupils with special educational needs) as reported to OFSTED, compared with DfES data on LEAs' total expenditure on mainstream transport in 1999/2000. Extreme outliers and LEAs with partially missing data have been excluded. Expenditure per day is calculated assuming a 190-day school year. Equivalent data is not available for Wales.

Expenditure per pupil carried per school day (£)



13. In Wales, LEAs spent over £50 million on free home-to-school travel in 1999/2000, about £40 million of which was on travel to mainstream schools and the rest on travel to special schools. The different proportions of spend on travel to the two types of school, compared with England, reflects the greater rurality in Wales.

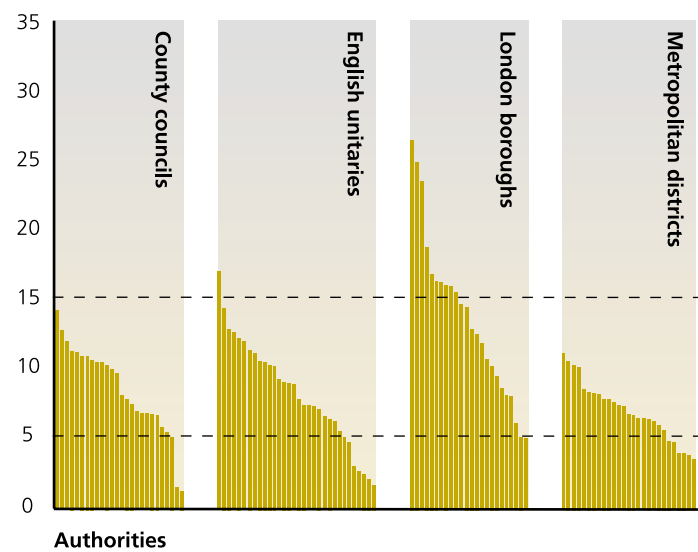
EXHIBIT 4

Average expenditure per pupil with special needs carried per school day in England in 1999/2000

Expenditure varies, but most LEAs spend between £5 and £15 per pupil carried per school day.

Source: Audit Commission analysis of LEA expenditure data collated by the DfES and LEA pupil numbers carried collected by OFSTED. The combination of data sets revealed some data errors – outliers have therefore been excluded. The graph is based on data from 109 authorities. Expenditure per day is calculated assuming a 190 day school year. There is no equivalent data for Wales.

Expenditure per pupil carried per school day (£)



Social services transport

14. There is little comprehensive national data on the cost of social services transport. For example, the Department of Health amalgamates transport costs with catering and other expenditure when collecting data on expenditure on personal social services. To add to the difficulty, in 1999/2000, a majority of English social services authorities did not give these amalgamated costs in their returns to the Department. The financial arrangements within many authorities, especially where responsibilities for transport are devolved to individual day centres, help to explain why it is so difficult to monitor transport expenditure centrally. There is a similar paucity of central data about the numbers of people carried.

15. Among authorities visited by the Commission, where it is possible to examine the numbers in more detail, expenditure on social services transport in 1999/2000 varied from about £450,000 a year to £2.8 million. Extrapolating from this data, plus the information that is returned to the Department, suggests that social services transport is likely to cost over £150 million a year and may be over £200 million nationally.

Non-emergency patient transport

16. Free non-emergency patient transport is used for a wide variety of purposes. These include bringing people to and from treatments such as renal dialysis¹, radiotherapy and physiotherapy; for attendance at mental health units; for other outpatient attendance at clinics and day hospitals; for x-rays and other tests; and for day surgery. Non-emergency PTS is also used to take people home following discharge from accident and emergency (A&E) or inpatient care.

¹ A patient undergoing dialysis will typically do so three times a week for life (or until a successful transplant). Transport arrangements can be particularly important to these patients, particularly where they live in rural areas and have to travel long distances for this life-saving treatment.

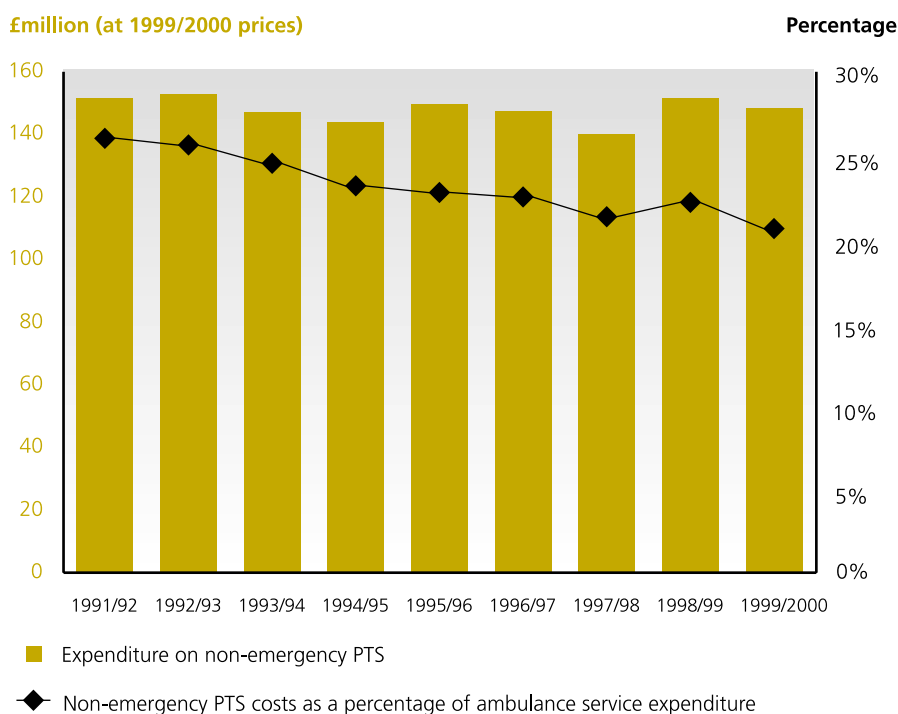
17. Although some hospital trusts provide non-emergency patient transport services in-house or use private sector providers, ambulance service trusts provide or arrange the great majority of non-emergency patient journeys. English ambulance service trusts provide about 14 million non-emergency patient journeys a year. The number carried has changed little over the last decade and equates to taking approaching 30,000 people to and from hospital each working day. This is far more patients than use emergency ambulance services – non-emergency PTS accounts for over 80 per cent of all patient journeys by ambulance in England. In spite of the much higher numbers carried, non-emergency PTS often has a much lower profile than the emergency service both within ambulance services and in the NHS overall.

18. English ambulance service trusts spend about £150 million a year on non-emergency PTS. This too changed little, in real terms, over the 1990s, even though total ambulance service costs rose. As a result, non-emergency PTS now accounts for a declining proportion of overall ambulance service costs [EXHIBIT 5]. It now represents about 20 per cent of total ambulance service expenditure compared with over 25 per cent early in the 1990s. On average a (one-way) patient journey in a typical ambulance trust cost about £9 in 1999/2000 [EXHIBIT 6, overleaf]. In the same year, the Welsh Ambulance Service provided about 1.3 million non-emergency patient journeys, equivalent to taking an average of about 2,500 people to and from hospital each working day. This rose to nearly 1.4 million in 2000/01.

EXHIBIT 5

Expenditure by English ambulance services on non-emergency PTS

Expenditure was relatively static in real terms in the 1990s but represented a declining proportion of overall ambulance service costs.



Source: Audit Commission analysis of Department of Health data

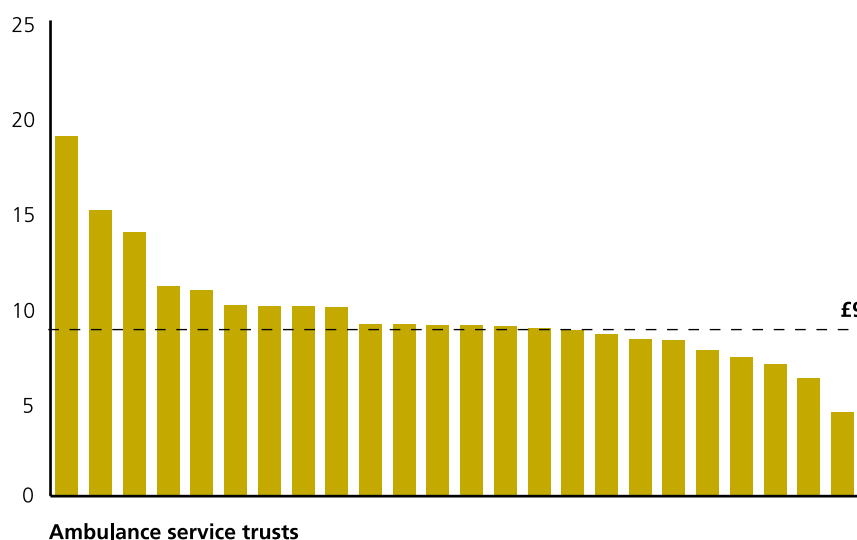
EXHIBIT 6

Average cost per (one-way) patient journey in England in 1999/2000

A single journey in a typical ambulance service costs an average of about £9.

Source: Audit Commission analysis of data provided by the Ambulance Services Association (ASA). Data is for the 24 English ambulance services that returned the ASA's questionnaire. Analysis includes 'escorts' (ie family or friends of the patient who travel on the non-emergency PTS). It excludes aborted journeys (ie, ones where the service calls for the patient but the patient does not travel, for example, because he or she is not in); ambulance services usually charge hospital trusts for these.

Average cost (£) per (one-way) patient journey



Managing, organising and providing the services

19. Arrangements in local government for managing, organising and providing home-to-school transport and social services transport differ from those used in the health service for non-emergency patient transport.

Arrangements in local government

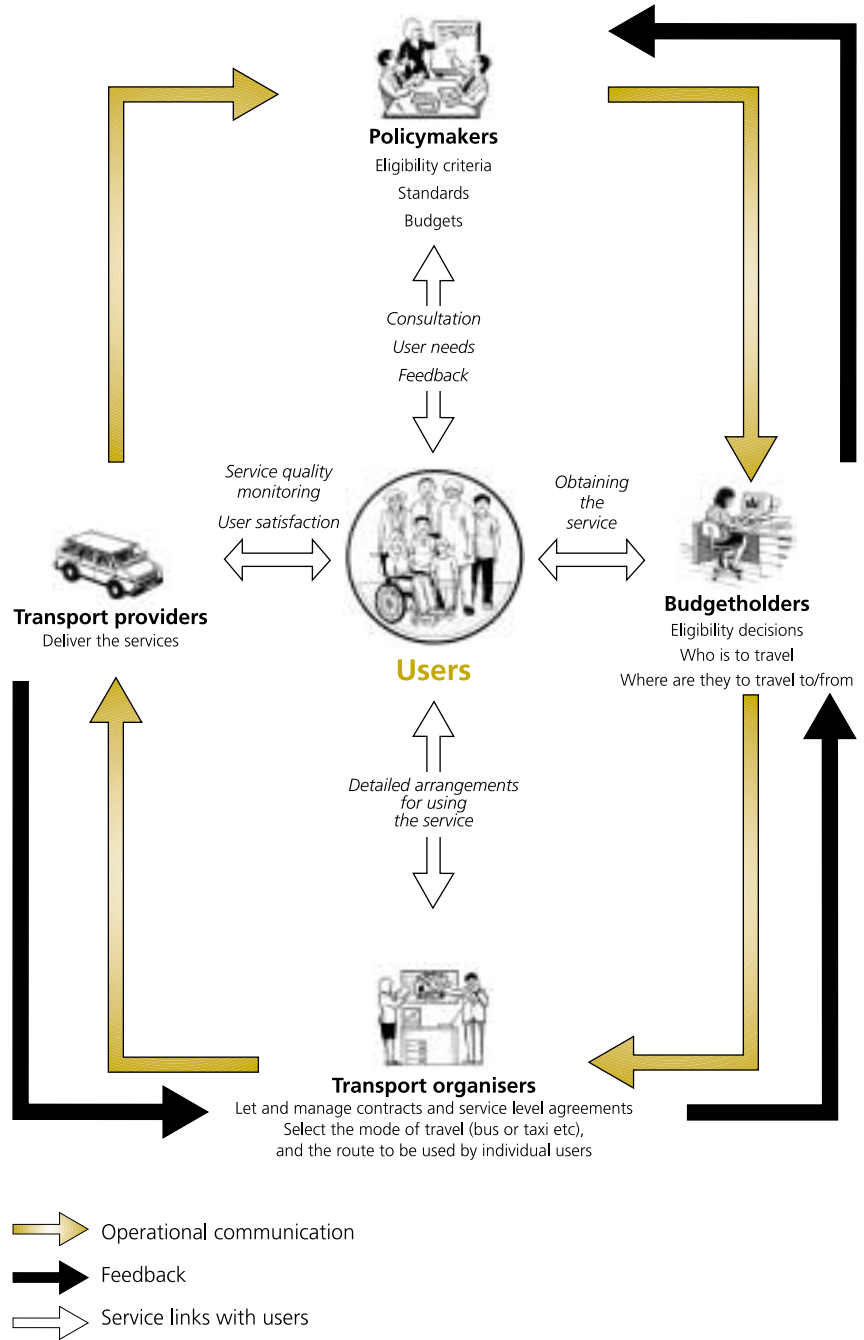
20. Users lie at the heart of modern public services. There are four distinct roles in providing them with a client-focused, efficient, effective, and well-managed transport service. Good communication with users, and feedback between those involved in providing the service, are essential. The roles are [EXHIBIT 7]:

- the *policymakers* (elected councillors supported by officers) who set the local policies on eligibility and service standards and budgets, after consultation with users;
- the *budgetholders* (typically officers in councils' social services and education departments) who have day-to-day responsibility for the service and may also have line-managerial responsibility for decisions on an individual child or client's eligibility for transport – thus special educational needs managers may manage the special educational needs element of the home-to-school transport budget and, in social services departments, individual day-centre managers may each have a transport budget;
- the *transport organiser*, whose responsibilities include making the detailed arrangements for individual users [BOX A, overleaf]; and
- the *transport providers* – these may be either in-house operators – internal trading organisations (ITOs) – or external suppliers, which include contractors supplying buses, coaches and minibuses and taxi and hired-car operators [BOX B, overleaf].

EXHIBIT 7

Arranging, managing and providing transport

There are four key roles; feedback is essential.



Source: Audit Commission

BOX A

The transport organiser in local authorities

The organiser acts as the budgetholder's agent. He or she receives transport requirements – service standards and details of who is to travel and the addresses between which they must travel – and plans, arranges and manages the necessary transport. The function is normally carried out in-house (though some authorities are examining possible outsourcing when carrying out best value reviews of transport) and is fulfilled in a number of ways:

- Some councils have separate organisers for home-to-school transport and social services transport, located in their respective departments.
- Others have a single, central transport co-ordinating unit that arranges transport for both education and social services.

This can allow authorities to make the best use of an important technical skill. It also guarantees that different parts of the authority are not bidding against each other to hire the same vehicles thus driving up price. It can also allow them to exploit economies of scale when letting transport contracts or using an internal trading organisation (ITO) – for example, by allowing vehicle pooling between social services and SEN transport work.

In county councils and unitary authorities, these units also typically deal with work arising from their councils' roles as transport authorities. For example, they may let contracts with commercial bus operators to provide subsidised, socially necessary public bus services.

In England, some of the six local Passenger Transport Executives (PTEs) act as agents for the metropolitan district councils in their areas, organising free mainstream home-to-school travel on their behalf. This travel usually involves either the purchase of bus (or rail or tram) passes or the letting of contracts for dedicated bus services by the PTE. Using PTEs thus offers similar advantages to the use of a central co-ordinating unit in a county council or unitary authority but allows co-ordination of arrangements across the metropolitan districts in the PTE's area.

Source: Audit Commission

BOX B

The transport provider in local authorities

Internal Trading Organisations (ITOs): Some authorities have separate ITOs for educational and social services work; others have combined units. Where ITOs are used, they typically sub-contract some of the work to taxi and private-hire operators.

External contractors: These include commercial bus, coach and minibuses operators and voluntary bodies, for example local community transport organisations.

Taxis and private-hire vehicles: These have an important role. Some people's journeys are difficult to accommodate economically on a bus, coach or minibuses route. Some in-year changes in the numbers to be carried, and the places children or social services clients travel between, can also be difficult to accommodate within the existing network. The needs or behaviours of some children and adults can mean that it is best that they do not travel with others.

Volunteers: In some councils, volunteer drivers are also used. Volunteers use their own cars, and typically receive a mileage allowance intended to cover the additional motoring costs they incur in providing this service.

Parents or carers: Parents and carers sometimes receive mileage allowances to take children, entitled to free transport, to and from school.

Source: Audit Commission

21. These roles are usually well delineated, though the distinction between the transport organiser and an ITO can be blurred when, for example, social services transport and special educational needs transport is provided in-house and external suppliers work as subcontractors to ITOs (as is common in London).

Arrangements in the NHS

22. The NHS guidance (Ref. 15) requires that eligibility for free non-emergency PTS be decided by individual general practitioners, for example, when referring a patient to hospital; by doctors within the hospital trust; or, on occasion, by dentists and midwives. NHS hospital trusts currently fund the service and set local quality standards. The transport is typically provided by ambulance service trusts or, less commonly, as at Guys and St Thomas, by in-house suppliers employed directly by the hospitals or by private contractors. More rarely, as at University Hospital Lewisham, a local authority can help to provide the patient transport service for its local hospital. Hospital trusts typically manage the services through a corporate services or facilities management unit. Local specifications and standards are usually developed by these central units and are often rolled forward from year to year without review or revision. They may not always reflect clinicians' current local priorities.

23. Hospital trusts often have agreements with more than one ambulance service, so that people travelling to the hospital from outside its area are carried by the ambulance service covering their home address. As a result, most ambulance services have many different agreements, some of which are worth less than £50,000 a year, and each of which will have its own contract terms, quality standards and managerial overheads [EXHIBIT 8]. Ambulance service officers interviewed by the Commission have argued that this causes them to use resources inefficiently, and that greater co-ordination of purchasing and fewer contracts are needed.

24. Subcontracting is common. For example, ambulance services may subcontract out-of-area journeys to other ambulance services or pass some work to taxis or minicabs or to private sector suppliers; and private sector suppliers sometimes subcontract work to ambulance services.

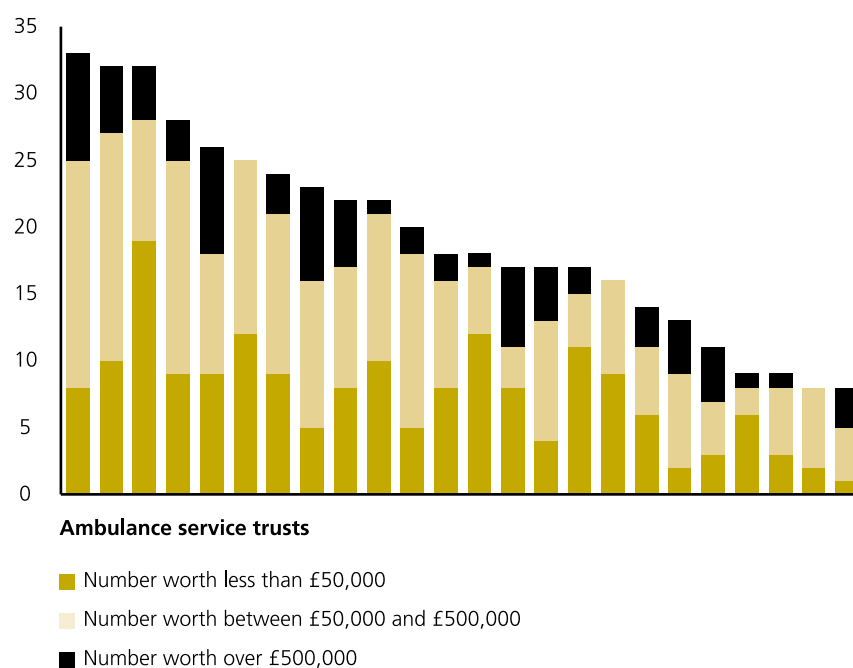
25. People who are able to walk unaided, at least for short distances, account for over half of the use of non-emergency PTS in most ambulance services [EXHIBIT 9]. Many other users can walk with some assistance. People travelling in wheelchairs are in the minority; patients on stretchers are even rarer, and chiefly make non-emergency inter-hospital transfers. Services also carry some family and friends of patients, as ‘escorts’. Most hospital trusts restrict the carrying of escorts, for example, to when the patient is a child, elderly or frail, has mental health problems or learning difficulties or ‘may be receiving bad news’.

EXHIBIT 8

Non-emergency PTS agreements between ambulance service and hospital trusts in 1999/2000

Most ambulance services have many different agreements, some of which are individually worth under £50,000 a year.

Number of non-emergency PTS agreements



Source: Audit Commission, using data provided by the Ambulance Services Association. Data is for the 24 English ambulance services that returned the ASA's questionnaire.

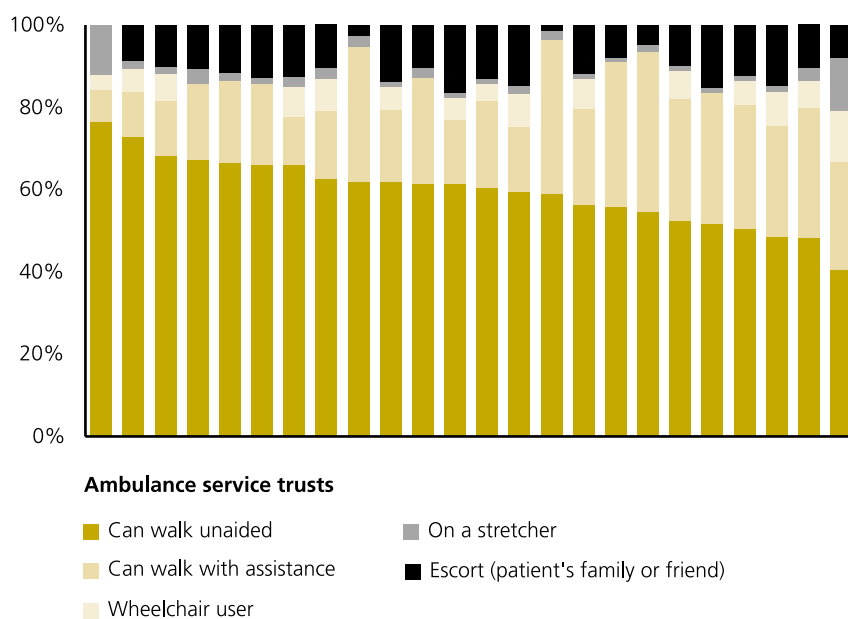
EXHIBIT 9

Users of non-emergency PTS in 1999/2000

People who are able to walk unaided, at least for short distances, account for over half of the use of non-emergency PTS in most ambulance services.

Source: Audit Commission using data provided by the Ambulance Service Association. Data is for the 24 English ambulance services that returned the ASA's questionnaire. The analysis excludes 'extra-contractual journeys' (ie, ones not covered by services' normal agreements with hospital trusts, for example, occasional long distance transport of a patient across the country). It also excludes aborted journeys.

Percentage of patient journeys



26. Ambulance services chiefly use a mix of multi-seat ambulances and cars to meet demand. The former are often similar to the minibuses used by local authorities to carry social services clients and those with special educational needs, containing both seats for people who are able to walk and space to carry wheelchairs. Cars include:

- taxi and hired-car services employed by the ambulance service trust – these are typically used for work outside the patient transport service's normal Monday to Friday hours, and tend to be used for work such as evening discharges from A&E units or evening or weekend discharges of inpatients; and
- voluntary car services (VCS), also sometimes referred to as ambulance car services (ACS) or hospital car services (HCS), in which volunteers use their own cars to carry people to and from hospital – ambulance services usually pay mileage allowances, intended to cover the additional motoring costs that drivers incur by acting as volunteers.

27. This use of volunteer drivers can be highly cost-effective (Ref. 19) and reflects advice from the Government that 'some non-emergency patients assessed as in medical need of transport do not necessarily require an ambulance. Full use should be made of alternative modes of transport, which provide a reliable and flexible service to patients' and that 'where a specialised vehicle is not required alternatives such as the Hospital Car Service should be considered' (Ref. 20).

Conclusion

28. Arrangements for managing, organising and providing the transport services covered by this report are complex and varied. Local authorities' internal trading organisations, bus and coach operators, voluntary bodies, taxi and hired-car operators, ambulance services and volunteer drivers all play a part. However, a description of the services from the provider's viewpoint can ignore whether the services actually meet the needs of their users.

29. Home-to-school transport, social services transport and non-emergency patient transport all exist to provide people with access to public services. The users include many of the most vulnerable people in society. People's experiences of the services are very varied and are likely to rise in response to a modernisation agenda, which advocates a more user- and patient-focused approach to services. The next chapter addresses what it is like to use the services.



2

Using the Services

Service users are diverse, ranging from older people to children, and from the healthy to those who have disabilities and special needs. Their experiences show that, while some are satisfied with their transport, others face inequity and inconsistency in the standard of service that they receive.

Complexity and fragmentation

30. Although there are satisfied users of transport services and good practices, there are also problems and difficulties:

- Complexity and fragmentation: many people are likely to be confused by the complex and fragmented arrangements that subsidise and support the travel of adults and children who have mobility difficulties or disabilities or who are injured or unwell.
- Fairness and equity when accessing the services: eligibility for home-to-school transport and non-emergency PTS varies from place to place. Where charges are levied, approaches to these also vary.
- Users' experiences: while some people are very happy with the services they use, there are also several commonly repeated areas of concern.
- Safety and service quality: these are often given insufficient prominence and sacrificed to cost issues.

31. Complexity and fragmentation are not especially an issue for children using mainstream home-to-school transport. However, they are for users of social services transport, special educational needs home-to-school transport and non-emergency patient transport.

32. These user groups overlap. For example, an older person might use social services transport to visit a day centre and the next day use non-emergency patient transport to attend hospital. Similarly, a child with special educational needs might use specialist home-to-school transport every school day, regularly use non-emergency patient transport to visit hospital and might occasionally use social services transport to travel to and from respite care.

33. However, children and adults who have physical disabilities, learning difficulties or mental health problems, and people who are ill or experiencing the frailties of age, also want to be able to go shopping, take part in leisure activities and visit family and friends. They also need to visit their GP, dentist or optician. But none of these needs is covered by social services transport, home-to-school transport or non-emergency PTS.

34. Some people are not able to use private transport for these purposes. This may be because they, or their parents or carers, cannot afford it. Car ownership is closely linked to income; under 25 per cent of lowest income households have a car compared to over 95 per cent of highest income households (Ref. 21). Elderly people, and children and adults who have disabilities, and whose households have low incomes, are particularly likely to face problems. For example, people who use wheelchairs need to travel in vehicles that tend to be larger and costlier than the average private car, increasing affordability barriers.

35. Alternatively, people may not use private transport for other reasons, for example, because:

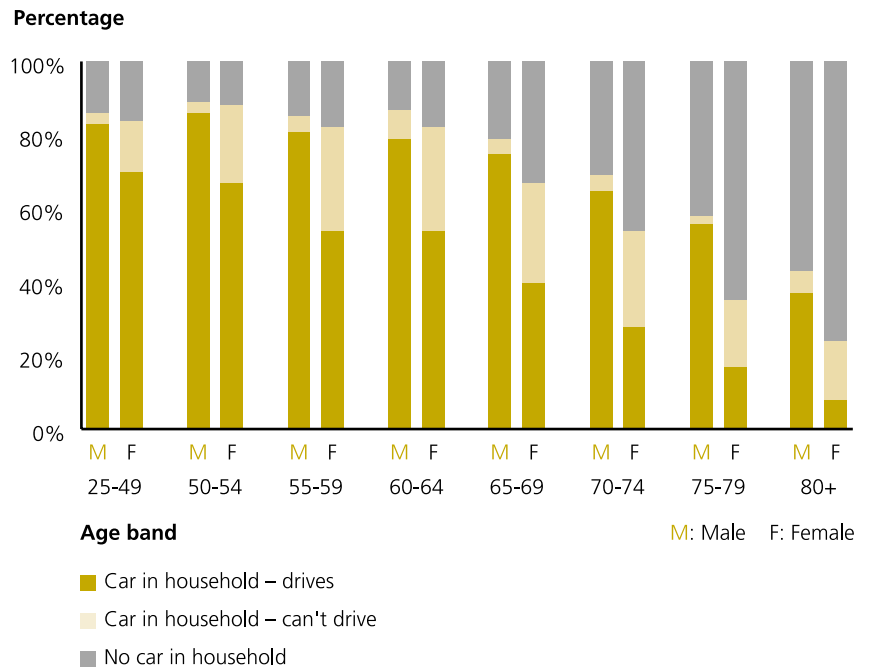
- No one in the household knows how to drive. While increasing proportions of older people have driving licences, many still do not, particularly older women. In the late 1990s, more than 60 per cent of men over 70 held a licence compared with under 25 per cent of women (Ref. 22).
- People are no longer able to drive. For example, over three-quarters of men and half of women who have given up driving and are aged 55 or more have done so because of some form of disability (Ref. 16).

Elderly women, most of whom live alone, are thus less likely than elderly men to have access to a car [EXHIBIT 10].

EXHIBIT 10

Age and access to a car

Older people are less likely to be able to drive or to be in a household with a car; elderly women are less likely than elderly men to have access to a car.



Source: Audit Commission using data from Ref. 23.

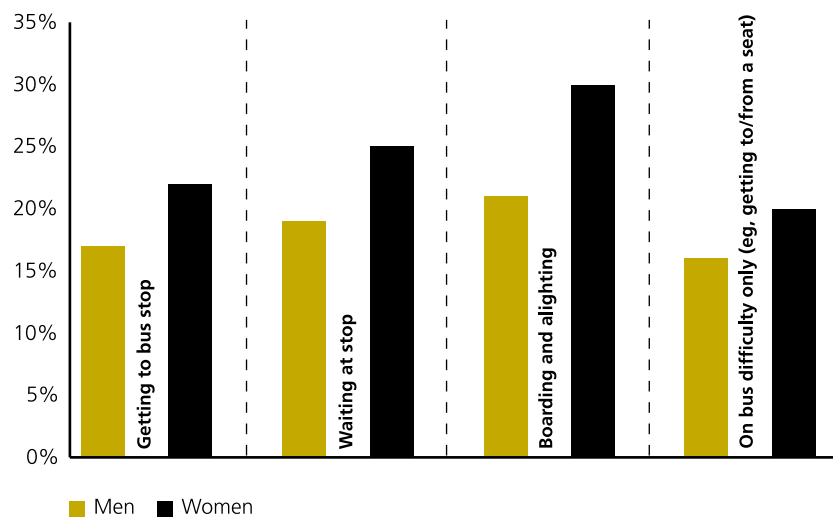
36. Some children and adults whose households lack access to a car are not able to use public transport. This may be because services in their area are poor, as is the case in some rural areas even since the introduction of better services funded by Government schemes such as Rural Bus Grant and Rural Bus Challenge. Even where there are adequate services, restricted mobility and other medical conditions, such as failing hearing or sight, breathing difficulties or communication or learning difficulties, may make it difficult to use public transport. For example, high steps getting on and off buses and trains, and steps at railway stations, present serious barriers to access for many people. Nearly a third of older women, and about a fifth of older men, in households that do not have a car, report difficulty using buses [EXHIBIT 11]. Being too frail and easily tired to travel to a bus stop, concerns about safety because of the poor condition of pavements or inadequate road crossing facilities and poor access to information about services are further barriers.

EXHIBIT 11

Using the bus

Nearly a third of older women, and about a fifth of older men, in households that do not have a car report difficulty using buses.

Percentage of older people in households without a car with a difficulty using buses



Source: Audit Commission analysis of data from Ref. 24.

Many children and adults whose households do not have access to a car are still unable, or continue to find it difficult, to use public transport.

37. The attitudes and behaviour of drivers or other passengers may also deter some others. An intimidating atmosphere on buses can generate feelings of insecurity. Insufficient handrails, overcrowding and erratic driving practices increase the risk – and the perception of risk – of accidents (Ref. 16). Older people, children, people who have hearing impairments or who have learning difficulties and people who have other disabilities or who are unwell are all likely to be particularly sensitive to these situations.

38. Initiatives such as the Department for Transport, Local Government and the Regions' (DTLR's) driver training seminars (Ref. 25) have sought to address some of the driver behaviour problems. The Disability Discrimination Act is removing some of the physical barriers. Regulations now require that all new land based public transport vehicles be fully accessible to people who have disabilities, including those who have to remain in their wheelchairs. But it will take many years to replace the entire national bus fleet; existing vehicles that are not fully accessible can remain in use until 2017. Many children and adults whose households do not have access to a car are still unable, or continue to find it difficult, to use public transport. Some of these travel by taxis or minicabs instead, but the cost of this can be a barrier to their regular use.

39. A wide range of schemes try to address these accessibility and financial barriers to travel [BOX C, overleaf]. The Department of Health's Hospital Travel Costs Scheme seeks to overcome affordability barriers to travel to hospital for some people who are not entitled to free non-emergency PTS [BOX D, overleaf]. In 1995/96, the last year for which the Department collected data, trusts and health authorities paid out £15 million on the scheme and other reimbursements to patients for travelling expenses.



BOX C

Schemes addressing accessibility and financial barriers to travel

Schemes include:

- **Public transport concessionary fares schemes for older people and people with disabilities:** Until this year, local authorities had discretion about whether to have such schemes. They are now required to provide ones that offer at least a half-fare bus concession but can have schemes that provide greater reductions in fares if they wish. For example, London boroughs and the Passenger Transport Authorities in Merseyside and the West Midlands are continuing to fund free concessionary travel in their areas. Concessions have successfully removed affordability barriers to bus travel by many older people (Ref. 16).

- **Dial-a-ride and ring and ride schemes:** These are specialist minibus services that offer door-to-door travel for people who have disabilities, including those who travel in wheelchairs. These usually charge users, at fares comparable to public transport rates, and are normally provided by voluntary bodies with grant aid from local authorities or other public bodies.
- **Taxicards:** Schemes, such as those funded by London boroughs, help people who have disabilities to pay for travel by taxi.
- **Voluntary sector community bus schemes and voluntary car schemes:** These tend to cover areas where there is no or little public transport. Drivers of community buses are unpaid.

The car schemes are similar to, but separate from, the hospital car schemes run by ambulance services. Volunteers use their own cars to carry passengers. Passengers typically pay the drivers a fare or mileage rate intended to meet or help to meet the drivers' additional cost. Drivers need to comply with all of the legal requirements for everyday motoring and to have appropriate insurance, but voluntary car arrangements are exempt from taxi and minicab licensing requirements, providing they are not profit making.

Source: Audit Commission

BOX D

The Hospital Travel Costs Scheme

The patient's travel costs are met if he or she is receiving income support, working families tax credit, disabled persons tax credit, or is a dependent in a family receiving income-based job seekers allowance or working families tax credit. Other patients on low incomes may apply to the Department's Health Benefits Division for full or partial reimbursement. In some instances, other patients may also become eligible, if they have to travel long distances frequently. Eligible

patients are also entitled to claim for the travelling expenses of escorts where this is considered by their GP or consultant to be medically necessary. Payment is based on the patient's entitlement and not on that of the escort.

Patients are reimbursed by the hospital on production of proof of receipt of the relevant benefits or, in other low-income cases, on production of a form issued to them by the Health Benefits Division.

Reimbursement is at the cost of cheapest available public transport (eg, taking account of concessionary fares) or, if private transport is used, the lower of the fuel cost (plus any unavoidable car parking charges) or the public transport cost. Taxi costs are reimbursed in 'exceptional cases' where there is no alternative to taxi use for all or part of the journey, for example because of restricted mobility or because public transport is not available.

Source: Audit Commission, drawing upon the Chapter 28, 'The Hospital Travel Costs Scheme' of 'The NHS Finance Manual' (Ref. 26).

40. Much of the support available to people varies according to where they live – dial-a-ride schemes do not yet cover the entire country; other voluntary schemes vary locally; Taxicard schemes are comparatively rare outside London; and concessionary fares schemes differ from place to place. In London, for example, dial-a-ride will not normally take people to hospital appointments, believing this to be an NHS function. There is, therefore, no obvious means of getting to hospital, other than possibly expensive taxis or minicabs, for people who the NHS decides do not have a medical need for non-emergency PTS but do not have access to a car and have mobility difficulties or other problems that prevent them from using public transport. Congestion charging in London may further complicate the position (although NHS patient transport vehicles and vehicles used by disabled people, which are not liable for excise duty, may be exempt from the charges).

41. Even where there is realistic support, people may have to deal with a number of organisations in order to go about their everyday business. For example, an elderly person with mobility difficulties, who cannot use public transport and who does not have access to a car, might use social services transport to go to a day-centre but dial-a-ride to go shopping, Taxicard to visit friends or relatives and non-emergency patient transport to attend hospital. If the hospital does not provide free transport, he or she might instead travel by taxi or minicab. If the patient is receiving benefits, he or she can recover the expense through the Hospital Travel Cost Scheme but would first need to be aware of the scheme – often it is not well publicised – and then go through the bureaucracy of claiming.

42. Elderly and unwell people are not likely to find this range of options easy to negotiate. Age Concern London found, when it examined travel to health services in the capital, that:

‘Over half of those travelling to hospitals and dentists, and a third of those using GP services or health centres, reported some difficulty getting there. Many interviewees might have been eligible for hospital or accessible transport services but either did not know about, or had chosen not to use them. They lacked information about options, had previously had poor experiences leading them to make their own arrangements or did not consider themselves disabled enough or likely to be eligible for ambulance or accessible transport ... A major gap was a lack of information and low level of understanding about the options for getting to health services... There appeared to be considerable misinformation about older people’s entitlement for different accessible transport services.’

A Helicopter Would be Nice, Age Concern, London, 2001 (Ref. 27)

‘The journey [to hospital] is a strain, it takes 30 minutes, but I don’t know any alternative.’

‘It takes about an hour and a half as I walk very slowly. There is no public transport.’

‘My leg seized up and I couldn’t move my foot’ [following a 15 minute walk to a bus stop to go to hospital for physiotherapy].

‘My wife has arthritis and angina. She is unable to attend medical appointments [by] herself, as she is unable to speak or write English. I am unable to go with her because of my own disability. When she has to go for her monthly hospital appointment, someone accompanies her to the bus and someone meets her at the other end. It is too far for us to afford a taxi.’

Source: Older Londoners, quoted in A Helicopter Would be Nice, Age Concern, London, 2001 (Ref. 27)

Fairness and equity when accessing the services

43. The National Association of Citizens Advice Bureaux (NACAB) has also recently reported upon the cost of travel to health services, in its report *Unhealthy Charges* (Ref. 28). It found that people entitled to help under the Hospital Travel Costs Scheme often do not receive it because:

- there is often little or no information given to patients about the help available to them;
- there can be difficulties in obtaining the relevant claim forms; and
- there is a lack of knowledge about the scheme by health professionals, resulting in misinformation to patients.

44. NACAB also described the Scheme as ‘flawed’ because, for example, it only covers travel to hospitals and does not give help if a GP refers a patient to a local clinic. Citizens advice bureaux clients in rural areas are particularly affected by inadequacies in help with travel costs.

45. Fairness and equity issues arise because of the ways in which local authorities exercise discretion in their award of free or subsidised travel to school and college, and in how health bodies interpret the medical need criterion for free non-emergency patient transport.

Home-to-school travel

46. Local authorities can exercise discretion about whether to provide free or subsidised transport to pupils and students who do not have a statutory entitlement to free transport. For example, some councils provide free travel for journeys below the statutory distance; some provide free or subsidised travel to schools other than the ‘nearest suitable school’; and some provide support for travel to post-16 education. Councils may apply a means test where travel is subsidised rather than provided free (that is, where parents and carers or students are asked to contribute towards travel costs). As a result, support for travel to education varies across the country [EXHIBIT 12, overleaf]. Appendix 4 gives more detail on the variation in policies between the authorities visited by the Commission.

EXHIBIT 12

Support for travel to education

This varies across the country.

Primary	Secondary	Full time education aged 16-19	Denominational schools
Statutory distances	Statutory distance	Free; to cease in 2004	Free; 8 mile cut-off
Statutory distances	Statutory distance	Half-fare passes	Free
Statutory distances	Statutory distance	Subsidised travel; free if pass means test	Subsidised travel; free if pass means test
Statutory distances	Statutory distance	Free	Free
Statutory distances	Statutory distance	Maintenance grant if travel more than 5 miles and pass means test	Free
Free if travel more than 1½ miles (to age 11)	Free from 2 miles	Free from 2 miles	As per primary and secondary
Statutory distances Discounted bus pass if travel less than 2 miles	Statutory distance Discounted bus pass available to others	Free if receiving Education Maintenance Allowance; otherwise half fare Smartcard scheme	Free
Free if travel more than 2 miles (to age 11)	Statutory distance	Subsidised travel	Free
Free if travel more than 1½ miles (to age 11)	Statutory distance from age 13 Free for 11-13 year olds if travel more than 2½ miles	Subsidised travel; free if pass means test and for third child and later children in family	Free
Statutory distances	Statutory distance	Half fare if receiving Education Maintenance Allowance; otherwise subsidised travel with higher subsidy if pass means test	Free

Source: Audit Commission. Free travel to denominational schools is usually based on similar distance tests to those used by the LEA for other free travel, use of the nearest suitable denominational school plus, in some instances, proof of membership of the denomination. For 16-19 travel, distance tests may also apply and support may be restricted to travel to the nearest appropriate school or college.

47. This variation is difficult to reconcile with equitable and fair access to education or with social inclusion; higher income households are more likely to be able to bear the costs of sending children to schools other than the ‘nearest suitable’ school and the costs of travel to post-16 education. Neither does it appear compatible with a national education policy that sees parental preference as a way of helping to improve school performance and that is moving towards greater specialisation by schools. The Department for Education and Skills (DFES) has also been reviewing transport provision and support for post-16 students in further education. Officials will be recommending to ministers that there be more consistency and equity in provision and support; the reform of legislation surrounding post-16 transport; and that LEAs take the lead in partnerships with colleges, local learning and skills councils and other key stakeholders to provide more effective transport arrangements.¹

Free non-emergency patient transport

48. The guidance on eligibility for free non-emergency PTS [BOX E, overleaf] is interpreted in varying ways. There are differences both across the country and within particular hospitals, with individual clinicians approaching the issue differently. These variations exist within a culture in which both administrators in hospital trusts and staff in ambulance services frequently place a strong emphasis on demand management (that is, on controlling the number of people using non-emergency PTS).

49. People with similar conditions and similar circumstances are thus treated differently depending on where they live. In some areas, demand management is relatively informal, focusing on GPs and clinics or consultants with high non-emergency PTS usage rates, who are reminded from time to time of the guidance on eligibility and about the cost of non-emergency PTS. Elsewhere, individual hospital departments have prepared formal criteria for their own use; and in other places, ambulance services and hospital trusts have consulted formally with stakeholders about how to interpret the guidance locally. The standard booking form used by the London Ambulance Service includes a set of questions to be asked of the patient by the GP or hospital booking the transport – ‘Is it possible for you to use public transport? If not, why not?’ ‘Is it possible for you to use a cab? If not, why not?’ ‘Is it possible for a friend or relative to bring you into hospital’. The East Anglian Ambulance Service has introduced a new non-emergency PTS ordering system in part of its area that includes an eligibility flowchart. In some areas, such as Surrey, free provision for ‘walkers’ is being particularly targeted, an approach that especially impacts on Ambulance Car Services.

¹ The DFES report is expected to be published in late 2001.

BOX E

Non-emergency patient transport

'PTS should be seen as part of an integrated programme of care. A non-emergency patient is one who, while requiring treatment, which may or may not be of a specialist nature, does not require an immediate or urgent response. A clinical need for treatment does not imply a medical need for transport. Medical need for non-emergency patient transport must be determined by a doctor, dentist or midwife and will depend upon the medical need of the individual patient, the availability of private

or public transport and the distance to be travelled. The principle which should apply is that each patient should be able to reach hospital in a reasonable time and in reasonable comfort, without detriment to their medical condition...

'Section 7 of the Health and Medicines Act, 1988 allows for a charge to be levied for the provision of transport to patients with a social need.'

Source: Ambulance and Other Patient Transport Services: Operation, Use and Performance Standards (Ref. 15)

50. The range of practice, and the ways in which people with similar conditions are treated differently in different areas, is illustrated by arrangements in Devon, Cornwall and Somerset. In Devon, a significant proportion of 'walkers', carried by Westcountry Ambulance Service's car service, are treated as 'social' provision. Patients are charged, with charges waived when patients meet the means-testing requirements of the Hospital Travel Costs Scheme. There are also reductions for frequent users of the service. The charges reflect the policies of the local health authorities in Devon, but are opposed by some patients and their carers [BOX F]. However, patients in the other areas covered by the same ambulance service – Cornwall and Somerset – are not charged. Westcountry is not alone in charging some NHS patients for transport, but such charging is relatively uncommon; none of the other ambulance services visited by the Commission during its study was charging patients. Some ambulance service officers oppose any charging by their services because of fears about VAT complications and that their voluntary car services might lose their exemption from taxi and minicab licensing.

BOX F

Renal patients' and carers' views on charging for non-emergency PTS

Some renal patients and their carers believe that patients are being treated unfairly and that there is a 'postcode lottery' on ambulance car service (ACS) charging. They argue that patients normally require dialysis three times a week, every week of their lives. In a rural area, parts of which are poorly served by public transport, some face long journeys to and from their dialysis centre. Even if they have a car, their renal problems may mean that they may not feel well enough to drive to dialysis. And, if they feel well enough to drive to the centre, they may not feel well enough after dialysis to then drive home.

Relying on family and friends to make an open-ended commitment to provide several hours of their time three days a week every week may not always be realistic. Use of

taxis or minicabs may not be affordable given the number and length of the journeys that some patients make. Paying to use the ACS service is cheaper but, even so, patients' groups report that some renal patients in Devon are paying £24 a week (over £1200 a year) to access NHS treatment and that even some patients receiving state benefits are being asked to pay £6 a week (over £300 a year).

Patients and carers in Devon perceive further anomalies – the charging regimes at different hospitals differ; and the patients receiving dialysis on the late evening, 'twilight', shift in Plymouth are taken home by taxi, as the ambulance car service does not provide a service at those times. These patients are not charged.

Source: Audit Commission

51. Conflicting arguments and views about free non-emergency PTS help to explain these differences. Many of those interviewed by the Commission who deliver non-emergency PTS ambulance services or who manage it on behalf of hospital trusts, argue that:

- some free transport is being provided for 'social' rather than medical reasons, that is, to people who have no 'medical' need for free transport but who have no car, are not served by public transport or who have mobility problems that require the use of accessible transport;
- non-emergency PTS may be being abused by some users, who have reasonable disposable incomes and/or their own cars but who use the service to save on travelling costs or car parking fees at hospitals;

- those who authorise use of non-emergency PTS rarely consider the cost implications of their decisions and are unwilling to refuse patients' requests for transport; and
- under the guidance, decisions on eligibility for free non-emergency PTS should be made by individual GPs, clinicians, dentists and midwives but, in practice, most GPs delegate the decision to their receptionists and many hospital clinicians delegate it to others such as nurses, occupational therapists and physiotherapists.

52. The position was very similar in 1990 when the National Audit Office (NAO) (Ref. 19) found that different eligibility policies operated locally, with major local variations in demand. The NAO also reported that senior ambulance staff estimated that 10 per cent of 'walkers' (patients able to walk unaided and who could travel in single-crewed ambulances or by voluntary car) were misusing non-emergency PTS as they could have got to hospital in other ways. It added that the Department of Health and Welsh Office had pointed out that ambulance staff's views on misuse were subjective opinions and not those of the doctors, dentists and midwives qualified to make a clinical assessment of medical condition. It also reported that nearly all ambulance services and health authorities found it necessary to manage demand within available resources. The NAO concluded that there was confusion about what constituted medical need for free non-emergency PTS.

53. The current guidance on eligibility (Ref. 15) was issued after the NAO had reported but has done little to clarify the position. In addition, the guidance now:

- refers to the need not to worsen patients' medical condition when they travel – this requires a clinical understanding of patients' conditions that administrators and ambulance staff may lack and may, for example, involve considering the possible impact on a patient's health of the stress that travel by means other than non-emergency PTS might cause; and
- has a requirement to take account of the availability of private or public transport and the distance to be travelled – difficulty travelling by other means is thus relevant to a decision on whether or not to provide free non-emergency PTS, but makes it less easy to differentiate readily between entirely 'medical' and entirely 'social' provision.

Users' and other stakeholders' experiences

54. The Audit Commission's discussion with transport users as part of the research for this report, and as part of its best value inspections and other work with local authorities, offer insights into users' views. So do the detailed consultations with users carried out by individual local authorities as part of best value reviews. Other research also highlights users' experiences, including work by Ofsted when inspecting individual schools, studies on bus use sponsored by the DTLR (Refs. 29, 30) and the work of bodies such as Age Concern London (Ref. 27) and the University of Westminster (Ref. 31). Some of this also gives insight into the views held by other stakeholders.

55. Stakeholders' perceptions of services inevitably vary; some people are pleased with the services. However, dependency on the transport means that some people using these services may be reluctant to express dissatisfaction. In the words of one volunteer working with renal patients, 'They're terrified of rocking the boat and therefore jeopardising what they've got.'

'[Non-emergency PTS] staff work hard...[and] treat you with respect and courtesy...in an ambulance I feel I am in a safe environment, I have trained assistants and facilities...they can treat me straightaway' [if complications arise].

Patient

'The taxi driver laughs and jokes with me. He sometimes writes notes to me and can sign a little bit.'

Deaf pupil

'My bus is new – it's immaculate – we went on a trip today to the park. Every day our driver sweeps out the step so the mechanism works. There's a happy atmosphere – they're laughing all the time.'

Parent of a child with special educational needs

'The drivers are very good.'

Adult with severe learning difficulties

56. However, other people are less satisfied, with certain common themes emerging:

- **The overall length of the patient day and poor communication when using non-emergency PTS** – the wait to be picked up, the wait to be seen at hospital and delays before being taken home, as well as the time on the vehicle and the lack of information about how long they will have to wait to travel or will spend on vehicles. In addition, medical staff have identified difficulties that transport problems sometimes cause to patient care and to the efficient use of NHS resources.
- **Unprofessional behaviour by some drivers and passenger assistants on special educational needs and social services transport.** Concerns include: a lack of awareness of, and consideration for, the needs of people with disabilities; rudeness; smoking on duty; swearing; and bad driving. This appears linked to weaknesses in some authorities' arrangements for deciding when to provide passenger assistants, for training drivers and passenger assistants and for providing them with appropriate information about passengers' needs. Approaches to the police-vetting of staff also vary and some authorities cannot be certain that everyone working regularly with children and vulnerable adults is suitable to do so.
- **Vandalism and bullying and poor quality vehicles on mainstream home-to-school transport.** Vandalism and bad behaviour means that some operators find the work unattractive and that they are unwilling to bid for contracts. Bullying means that some children do not use buses to go to school. Poor vehicle quality reflects a strongly finance driven approach to the service. There are also some concerns about poor driving and surly behaviour by drivers.

Non-emergency patient transport

57. Long journeys and long waits in hospital can have a particular impact upon people who are injured, ill or who have disabilities. Patients may need to take medication and, because of the tests or treatment they are to receive, may not have eaten before leaving home. The environment in which they wait is also important to their comfort and well-being. Some hospitals have well-appointed transport lounges where patients can wait in comfort, with good access to toilets and phones, and where they can readily obtain food and drink. But others do not. As the NAO has pointed out (Ref. 18) such lounges have other advantages; they can also be used by patients who are being discharged, as they wait for transport home, releasing beds earlier in the day.

58. Journey times obviously depend on the distance to be travelled and local traffic conditions, on the number of other patients to be picked up by a vehicle and how long it takes for passengers to get on or off the vehicle. While, in an ideal world, patients would get to hospital quickly, arrangements designed to improve provider efficiency (for example, using larger vehicles or extending routes to maximise the percentage of seats occupied) may increase journey times.

‘Be ready for 8 o’clock. 12 o’clock comes. Do we ring? [We] get told, “[The ambulance service] don’t pick up [at a particular address] until 11.00 am”.’

‘My biggest criticism is time delays. I have to be ready for 7.00 am but they probably don’t arrive until 9.30...Your tablets are timed...three and three-quarter hours was the maximum time to wait after clinic, but you are so grateful someone was going to take you home...’

‘I carry things around with me [producing water bottle and food from bag]. I always have these with me. Even here. I have to go upstairs [to the hospital café]. If you are blind you haven’t a chance.’

‘When it was essential I had to be at hospital [for radiography treatment] I thought, all this for five minutes in the theatre, under the gun for three and a half seconds...seven hours maximum for five minutes in the operating room. I had to be ready at 12.00 noon...The longest I had to wait was three hours, which worried me but didn’t seem to worry them.’

Patients

- 59.** Complaints about delays and waiting are, commonly, linked to:
- block bookings for some appointments (for example, for day surgery);
 - operational constraints, which mean that non-emergency PTS arrangements for a day are normally decided only on the preceding working day – this is because most days’ pick-ups contain a mix of long established clinic appointments, known well in advance, and others made at short notice – leaving insufficient time in which to notify patients of their likely pick-up times;

- therefore telling everyone to be ready by the earliest possible pick-up time (for example, telling everyone with a 10.00 appointment to be ready by 8.30, even though only the first patient will be picked up then and the last one on a particular route may be collected 45 minutes or an hour later) – offering the same pick-up time to everyone means that many people wrongly believe that their transport is late; elderly patients, in particular, can become anxious, believing that they will miss their appointment; and
- difficulties predicting when patients will be ready to return home – allocating patients to vehicles in ways that use resources efficiently on return journeys may mean long delays for some as they wait for the last person who is to travel on their vehicle to be seen in clinic or to finish their treatment.

60. In some places, delay can be compounded by problems with portering arrangements within the hospital or a lack of wheelchairs, which delay patients' transfer between the PTS reception and waiting area and clinics or other parts of the hospital. Ambulance services also report instances where appointment times are earlier than the start of the non-emergency PTS service, forcing them to deliver patients late. This reflects a lack of knowledge of the service by those arranging appointments and booking transport but may also show that service patterns no longer reflect local needs.

61. The Commission has identified few other complaints about services but where problems do occur they can be highly distressing for patients.



‘We are unable to take my wheelchair as my husband is unable to manage this and help me too on the journey. I therefore have to walk between the station and the hospital which causes me great pain...There is of course a car service for those who really need it. We have tried this, but find the whole experience humiliating and degrading, and therefore choose not to travel this way unless we really have to...When we do travel by car, the drivers do not seem to realise they are carrying sick people. Many of them drive too fast and erratically, take short cuts, use many roads with speed humps, do not speak to patients and do not help patients out of the car on arrival at their destination. I was violently sick in a car once, due to the driver’s atrocious driving...Patients who have many health problems and difficulties are made to feel like cattle being carted from one place to another.’

Letter from a renal patient to the Audit Commission

62. Successful non-emergency PTS is rarely likely to draw attention to itself, but poor services not only reduce service quality and the focus on individual patients, but also have significant impacts on hospital trusts and on the care they provide. For example:

- Poor organisation of non-emergency PTS can mean patients arrive late for, or in the extreme, fail to attend, outpatient and other appointments – this potentially damages the patient’s health as well as reducing the efficient running of clinics.
- Day hospitals rely on non-emergency transport – if patients arrive late, any timetabled work (for instance assessments by clinicians, as well as physiotherapy and chiropody services) may be disrupted.
- A lack of transport can lead to delays in patient discharge, resulting in bed blocking in hospitals.

63. Some clinical staff have told the Audit Commission of repeated problems with late arrival of transport which is compromising patients' treatment. In one surgery department, staff preferred to bring patients using non-emergency PTS to the hospital on the night before an operation in case they failed to arrive on time for their anaesthetic or operation. In other cases, the staff were requesting that patients arrive earlier than their scheduled appointment times to allow for 'anticipated' delays in patient arrivals.

64. In some cases, hospital departments need to give notice of a day or more to non-emergency PTS managers to obtain transport; missing a 1.30 or 3.00 pm deadline for a 'next day ambulance' order can lead to an extra day's stay in hospital. Missing the deadline on a Thursday, and an absence of non-emergency PTS in the evenings and at weekends, can lead to a patient having to stay for the whole of the weekend. Problems in arranging transport for home visits prior to discharge can also lead to bed blocking.

'The elderly clinic is on the same day as the anti-coagulation clinic and renal clinics, which get priority for transport in. The clinic runs from 9.00 am – 1.00 pm. Doctors can turn up at 9.00 am and patients are delivered at 12.00 noon...Sometimes we wait and then they don't come at all. Last Thursday there were more "did-not-attends" than arrivals – virtually all due to transport.'

Hospital doctor working with older people

'Every single day we have late transport. We have the equivalent of three flights a day at 8.00 am, 2.00 pm and 6.00 pm. We close at 11.30 pm, so often those who dialyse late have a shorter session. Over a long period of time they suffer and are not getting their full treatment.'

Senior nurse, renal services

‘[We have a one stop clinic where] the patient has to be scanned and see the doctor straight after – if you miss your slot it’s a problem. People need to be scanned by 1.00 pm so if they’re not turning up till 1.00 pm then you have to run around and try and find a doctor who may have gone. We don’t send people home but doctors run strict hours so it can prove difficult.’

Nurse in surgery directorate

Source: Audit Commission based on interviews with hospital staff

Special educational needs transport and social services transport

*‘There was a child with a degenerative heart condition. The escort noticed the child had gone grey. We thought he’d gone. We couldn’t feel a pulse. We had to come back to the school.’
(The child recovered)*

Driver

65. Special educational needs transport and social services transport typically carry vulnerable children and adults who require supervision and who may require care when travelling. Users can occasionally become ill on vehicles. They may also need to receive medication, either in response to illness or to ensure that they take their medication at the right times. Some children and adults may have challenging behaviour or present other problems when travelling, to which staff need to respond. Staff also help to load wheelchairs on and off vehicles and assist other passengers with mobility difficulties as they board and leave the vehicles.

‘[The social services client] suffers from autism. She is a young lady of 21 stone in weight and through her illness either seeks or shuns attention. Her behaviour can become disturbed and results in aggressive and occasionally violent episodes...Occasional violent behaviour [is a] risk to passengers/crew/other road users...The likelihood of incidents...is high. The degree of injury varies from lacerations caused by scratching, to a risk of a more severe injury being caused if someone was struck by a heavy object such as a seat or being hit by broken glass.’

‘[The social services client] is a double amputee who weighs in excess of 24 stone and uses a heavy electric wheelchair.’

Risk assessments carried out by one authority’s transport service

66. However, local authorities differ in when they provide passenger assistants and in the training, including disability awareness and customer-care training, that they give to passenger assistants and drivers. They also differ in the amount of information that they give to them about the needs of the children and adults that they are transporting and escorting. The variations in authorities’ approaches mean that children and adults with similar needs travel with passenger assistants in some authorities and without them in others. The differences in training are illustrated by social services transport. When the service is provided in-house, drivers and passenger assistants may work as care assistants when the vehicles are not in use and have received their authorities’ standard care training. But other drivers and passenger assistants, whether working for ITOs or contractors, have not always received necessary training.



A child travelling on special educational needs transport had had a tracheotomy and breathed through a tube in his throat. The passenger assistant on the vehicle had to be alert in case the tube blocked and had regularly to clear and, on occasions of emergency, replace the pipe during the journey. She sat behind the child and said that she had to act immediately if his head slumped forward as this might indicate that the tube was blocked. The assistant was also supervising two other children during the journey, one of whom suffered from a condition that might cause the child to have a fit. She had trained another member of staff to look after a second child with a tracheotomy, who travelled on another vehicle.

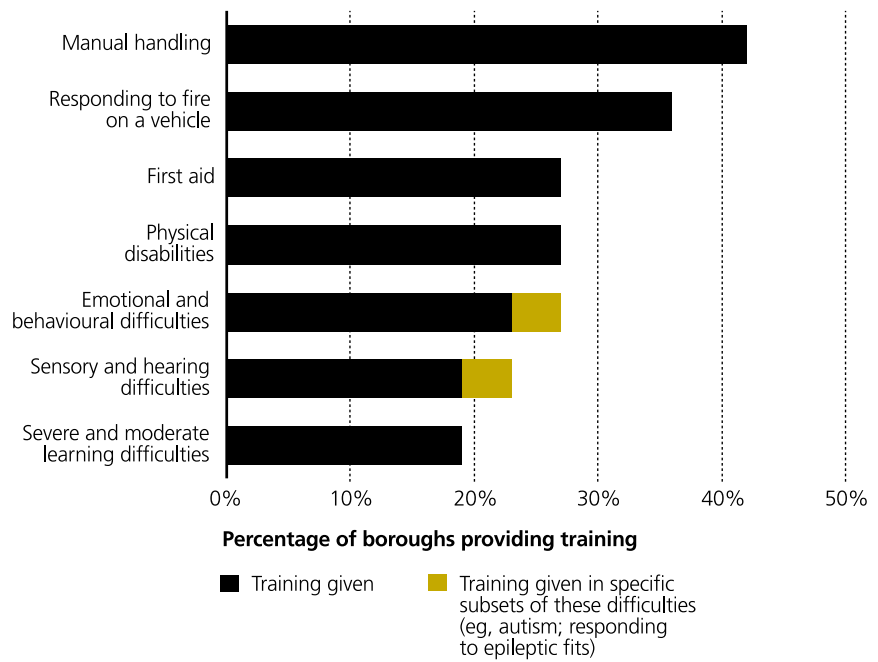
Audit Commission fieldwork

- 67.** The training given to drivers and passenger assistants on special educational needs transport also varies. In London, for example, only a minority of boroughs report giving first aid training to special educational needs passenger assistants [EXHIBIT 13, overleaf]. Yet some boroughs, such as Newham provide such training. At Lewisham, staff practice emergency vehicle evacuation procedures with the aid of a smoke machine.
- 68.** Authorities that use a mix of in-house and contract provision sometimes apply different standards and requirements to the two types of provision. Taxi and minicab drivers and agency or temporary staff used by ITOs and contractors are particularly unlikely to have been formally trained. These differences and variations help explain some of the inappropriate behaviours by some drivers and passenger assistants about which users, parents and carers have complained. Some of the allegations made to the Commission have been serious – for example, a parent who said he had seen drivers smoking cannabis in front of children and noticed drivers who smelt of alcohol.

EXHIBIT 13

Training passenger assistants working on special educational needs transport in London

The training given to passenger assistants varies considerably.



Source: Audit Commission survey. Based on data from 26 boroughs. Two boroughs that did not train passenger assistants before they started work report giving training later.

‘I couldn’t see properly because I’d only just had an eye operation a while ago and the escort let me tumble off the coach and never said anything.’

‘I had to share with someone and this guy had a minor epileptic fit and the taxi driver panicked – he didn’t know what to do. We had to get help in the end. If I hadn’t been there...the driver nearly lost it.’

Social services clients

‘I don’t like my taxi driver now because he doesn’t let us stop to go to the toilet.’ [This child attends a residential school and has a long weekly journey to and from home.]

‘I don’t like the taxi driver talking about my mum and saying that she looks nice and that she’s got a nice figure.’

Children with special educational needs

‘One day [the driver]’s chatty, another day he’s downright rude, he practically throws my daughter in...if I take too long [taking the child out of the house] he’s quite rude.’

‘I think he [the driver] shouldn’t be allowed to drive because he breaks the speed limit. He sets off at about 50 miles an hour.’

‘[The] children were sworn at by the cab driver and he asked them to get out.’ [The driver was subsequently disciplined].

Parents of children with special educational needs

69. OFSTED has on occasion commented upon shortcomings in passenger assistant training. Some drivers and passenger assistants are unhappy with what they see as weaknesses in their understanding of clients’ and children’s problems and of how to respond to them. In one authority visited during the Commission’s study, the LEA was not providing drivers or passenger assistants with information about children, on confidentiality grounds. The issue has also arisen in two recent best value inspection reports on other authorities [BOX G].

BOX G

Training and providing information about passengers’ needs

‘They [passenger assistants] have received no training on escorting pupils with serious medical conditions or in the safe lifting of pupils, and have no list of emergency medical telephone numbers...’

Ofsted inspection report on one special school

‘The issue of information available to staff on medical needs of customers needs addressing to ensure that they are trained and feel able to cope with all situations.’

‘Staff reported that there was confusion over the information about the needs of individual service users that they were entitled to know about. Some staff reported that they received adequate information...others reported that they did not...[and] were not aware of serious medical conditions until there was an unexpected problem.’

Best Value Inspection Service reports on two authorities

70. Poor training may mean that authorities either lack adequate safety arrangements or that procedures are not followed. OFSTED inspection reports on special schools have occasionally drawn attention to weaknesses in the procedures followed when children disembark from vehicles on reaching school and to problems caused by vehicle congestion [BOX H].

71. The headteacher of one special school visited during the study described two other difficulties caused by poorly trained or supervised passenger assistants. Firstly, her school has a policy of not responding when pupils with behavioural difficulties use foul and abusive language. However, some passenger assistants tell the child off or threaten to report the pupil to the school or to his or her parents. Secondly, passenger assistants standing outside the school can see through the glass front door into the school hall where some lessons take place. The Head had to intervene to stop passenger assistants, whose vehicles had arrived early, from rapping on the glass to try to persuade teachers to end lessons and let the children out early.

BOX H

Leaving the vehicle on reaching school

'The small car parking area does not allow for the safe movement of taxis when delivering and collecting pupils... a significant health and safety hazard...'

'An informal approach to health and safety has resulted in the school becoming "comfortable" with situations that may be hazardous. For example, when children are getting out of their taxis, cars going to the social services centre next door often pass uncomfortably close. The school is not undertaking any form of risk assessment ...'

'The arrangements for pupils' arrival at school by transport is unsafe. For example, minibuses arriving late

drive through children already playing on the playground. The speed of these vehicles is excessive. The departure routines, more closely organised and monitored by many more staff are much safer.'

'The arrangements for the transport of pupils and their setting down at the school are unsatisfactory, as there is a lack of suitable training for escorts and present arrangements for the arrival of pupils at school are potentially unsafe...While pupils are being unloaded or are walking into school, other vehicles are arriving and departing alongside them. These arrangements are unsatisfactory

because they are putting the safety of pupils at risk. Parents expressed concern over transport arrangements at the pre-inspection meeting.'

'The governors should seek the help of the local education authority to reduce the congestion caused by the arrival and departure of pupils' transport and in the meantime to provide directive supervision of the arrival and departure of such transport so as to reduce the potential hazards to the safety of pupils.'

Source: Audit Commission analysis of OFSTED inspection reports

'I assume vetting is done – but I think it's another area that needs looking at – sometimes the council does it, sometimes the driver is expected to do it. Taxi drivers and their integrity vary enormously.'

Interview with staff at a special school

72. Drivers and passenger assistants on special educational needs and social services transport should normally be screened with police^I, if they are working regularly in a supervisory capacity with children or vulnerable adults. However, checks can take a long time – late in 2000, London boroughs reported that, on average, police checks took between 10 days and 22 weeks. Delays create pressures to allow new employees or agency staff to begin work before vetting has been completed^{II}. Because of this, and weaknesses in ensuring that contractors have screened their drivers and passenger assistants, some authorities have no assurance that everyone regularly driving or escorting children and vulnerable adults and performing a supervisory role, is suitable to do so.

Mainstream home-to-school transport

73. Pupils who receive free bus passes are likely to have similar views and experiences of bus travel to those of other young people. Research by the DETR has found that almost a third of 10-12 year olds said they had been 'bullied by young people from my school/another school' and that nearly 70 per cent of those aged 13 or over had experienced rudeness when using buses, either from an adult passenger or driver, or bullying by other young people or had something stolen from them. Pupils sometimes complain of overcrowding and the cleanliness of the vehicles. Some also complain about drivers' behaviour towards them but can be unaware of the impact of their own actions on others and not realise that drivers, when being rude or surly, can be responding to poor behaviour by some children and young people (Ref. 29).

74. There is thus a danger of a vicious circle in which children's behaviour creates attitudes and behaviour by drivers that in turn exacerbate the children's behaviour. Early in 2001, the then DETR launched a series of training seminars for bus drivers. These had been developed by Crime Concern, the national, independent crime reduction organisation, offering drivers advice on the causes of conflict with pupils, factors that affect young people's behaviour on buses and how to deal with confrontation (Ref. 25).

I As required under the Protection of Children Act 1999 and the Care Standards Act 2000.

II This may change. The new Criminal Records Bureau, an executive agency of the Home Office, is offering disclosures of criminal record and other checks on employees from Spring 2002. Local authorities and other employers will deal directly with the Bureau when vetting employees, rather than asking individual police forces to carry out checks, and can already register with the service.

‘The worst problems are on the buses – drivers ignore us, they are rude, they swear or shout, they drive past bus stops where there are groups of young people, and they try to close the doors when we are getting on.’

Young Asian woman in South London school

‘Just look at the state of some of the buses...the seats ripped, it smells.’

Young woman in Newcastle

Source: Young People and Crime on Public Transport, DETR, 1999 (Ref. 29)

75. Operators report very bad behaviour by some pupils [BOX I]. Behavioural problems were also raised by teachers and LEA officers, drivers and operators interviewed about dedicated home-to-school transport during the Commission’s research. Some of the incidents reported to the Commission by operators are serious, for example, one in which a driver’s eyesight was damaged after a child shone a laser-pen into his eyes. Councils also report disturbing incidents – for example, one reported that children had cut headrests from seats and thrown them at the driver. Parents, consulted during some authorities’ best value reviews of home-to-school travel have expressed similar concerns. And, on occasion the issue has featured in Ofsted inspection reports on individual schools [BOX J].

BOX I

Operators’ concerns

‘Bus operators recount tales of vandalism and mayhem. Whilst damage to seating is most common, pupils have set light to vehicles, used hair sprays as flame throwers and broken or wrenched out

windows...It is small consolation that behaviour may be better in the mornings than at the end of the school day...The behaviour and total disregard for road safety displayed by pupils milling around roads and

pavements close to schools is a fair reflection of an attitude which does not improve once the bus is boarded.’

Source: Young People and Crime on Public Transport, DETR, 1999 (Ref. 29)

BOX J

Parents’ concerns

‘Many parents have indicated their concerns about the overcrowding, rough and unsafe behaviour which occurs on some buses used to

transport pupils to and from school. The school shares these concerns and is seeking to negotiate with the bus company improved provision to

resolve these problems.’

Source: OFSTED inspection report of one urban school

76. There are examples of LEAs, schools and operators that are working together to address problems. For example, Devon County Council has developed a protocol that sets out action by operators, the LEA and individual schools. The intention is to identify and investigate vandalism quickly so that pupils can be interviewed at school either later that day (if an incident occurs in the morning) or at the start of the next school day (if it occurs in the evening). The former DETR's report on young people and crime on public transport (Ref. 29) cites a number of examples of good practice for combating vandalism, as does the recent report by the Association of Transport Co-ordinating Officers (Ref. 32). But, where problems do occur, they are likely to have an impact on the availability, or on the cost, of operators' services [BOX K].

77. Increased supervision on vehicles is one possible answer but remains comparatively rare. Though some authorities provide passenger assistants for primary age children travelling on mainstream home-to-school transport, supervision and escorting on secondary transport is rare. The likely costs help to explain this; officers at one county council visited during the study estimated that it would cost several million pounds a year to provide supervision on all the county's home-to-school routes. Some transport professionals doubt its effectiveness, asking what legal powers passenger assistants would have to intervene if there was serious misbehaviour on a vehicle. In contrast, the headteacher of one school visited said that he would like supervision on buses, to deal with behavioural problems. He compared the expectation that there would be one teacher to 20 pupils on a school trip with the absence of supervision on home-to-school transport.

BOX K

The impact of vandalism on the local market

One LEA has used six different operators on one of its routes, each of whom has withdrawn from the work. Only one operator tendered for the current contract; the LEA is concerned that, if this operator also withdraws, no one may be prepared to provide the service.

In another area, the main transport provider recently withdrew from certain home-to-school routes, citing problems with pupil behaviour and on-board supervision.

Source: Audit Commission fieldwork

78. A strongly price-driven approach to awarding contracts for home-to-school transport means that vehicles can be old and their quality and comfort low. For example, one authority's best value review consultation with parents identified complaints about the buses rattling and smoking, and exhaust fumes leaking through rear seats. In one authority visited, children reported travelling on a vehicle that had a hole in the floor through which they could see the road; the authority confirmed that it had taken action against the operator about this incident. Poor quality vehicles may be compromising safety in other instances [BOX L].

BOX L

Operation Coachman

During Operation Coachman, an annual two-week national check of public service vehicles, the police and Vehicle Inspectorate banned 250 school buses (7 per cent of vehicles inspected) in March 2000 until their defects had been remedied. Thirty-six police forces across England and Wales inspected 3,712 vehicles including coaches, buses, minibuses and private hire vehicles. Problems they found included: oil or fuel leaks, structural faults, speeding and driving offences by drivers and uninsured and banned drivers at the wheel.

In the national check in 2001, about 10 per cent of over 1,600 vehicles inspected, were banned. Bob Tatchell, the operation's director, noted, 'Although the results are disappointing, the higher prohibition rate [than last year] is because buses and coaches which take children to and from school are normally from the older section of the PSV fleet. We are concerned that many of the defects could have been identified by the driver before he commenced his journey if he had completed an adequate check of the vehicle before starting out.'

Source: Audit Commission based on information provided by the Vehicle Inspectorate

Safety and service quality

79. Safety is a paramount issue; local authorities and health bodies must meet health and safety and other legal obligations. As this chapter has shown, variations in policies on escorting, differences in training and in staff vetting, and an emphasis on lowest cost provision, mean that arrangements in local authorities sometimes have weaknesses. Patient care on non-emergency PTS should be provided to a common standard as crew normally should be trained to the NHS's standard non-emergency PTS crew requirement. However, standards for Ambulance Car Schemes (ACSs) vary more. For example, ACS drivers are not normally trained to ambulance crew standards; while some service agreements specify that volunteer drivers have to receive first aid training, others do not. Specifications may say nothing at all about the training of taxi drivers, who rarely receive any specialist training. Some ambulance services trusts provide their ACS drivers with mobile phones, with which to contact the service if passengers are taken ill during a journey, others do not. In one area where taxis were being used regularly to transport patients, a driver described taking a heart transplant patient on a long journey to receive test results. The patient became very ill causing the driver great concern. On arrival at the hospital the patient had to be assisted by paramedics and re-admitted to the hospital.

'Drivers are not taught CPR (cardio-pulmonary resuscitation) or first aid. If something happens, [during a trip] you've got to get out there and do the business. This training should be a standard thing for voluntary drivers...The ambulance service does not provide mobiles to drivers. If you've not got a mobile phone and you are doing a rural service [you could have problems]...'

Ambulance Car Service driver

80. There are at present no nationally agreed minimum quality standards for either non-emergency patient transport or for the transport services provided by local authorities. Instead, quality standards are set locally. They vary considerably not only from place to place, but also within local authorities. A council's special educational needs transport arrangements and its social transport arrangements may work to different standards. And both of these may differ from the local standards for non-emergency PTS. For example, local authorities usually insist that all their minibus-based services have forward facing seats, because, in an accident, the risk of injury is greater with side facing seats. Some ambulance services have not yet fully phased out vehicles that have side-facing seats. Such differences create potential barriers to co-operation and better integrated services.

Non-emergency PTS

81. Quality standards for non-emergency PTS are set locally by hospital trusts. As one ambulance service usually works for many hospital trusts, a single service may work to several different standards. These standards have been influenced by the *Guidelines for Setting Non-urgent Patient Transport Standards* (Ref. 33) circulated by the NHS Management Executive in 1990. They try to address issues that are central to users' concerns – to limit the time spent on vehicles; and to ensure that most patients arrive before their appointment time, while also ensuring they do not arrive so early that they have over-long waits to be seen. They also seek to manage how long people have to wait for their transport home, after they have been seen. Standards are usually defined statistically or in terms of time bands [BOX M], which helps to explain why staff providing the service can be more sanguine about arrival times for clinics than patients.

82. Some clinics block book appointments for the same time in response to poor timekeeping by non-emergency PTS, to try to ensure that some, if not all, patients arrive by the time the clinic starts. In doing so, they have risked creating a vicious circle in which non-emergency PTS providers increasingly treat target arrival times as unimportant. This too helps explain why staff providing non-emergency PTS are less concerned than patients about arrival times.

83. Non-emergency PTS service agreements may also specify how staff are to relate to patients [BOX N, opposite].

BOX M

Examples of non-emergency PTS service standards

'Time on vehicle: The [Ambulance Service] will ensure that 90 per cent of all patient journeys within the local and neighbouring area take less than 60 minutes.

Outpatient arrival: The [Ambulance Service] will ensure that 90 per cent of all patients arrive...within 30 minutes each side of their appointment time.

Outpatient pick up: The [Ambulance Service] will ensure that 90 per cent of all patients arrive...within 60 minutes of being booked ready.'

Source: Audit Commission from one hospital trust's agreement with an ambulance service

BOX N

Non-emergency PTS – Customer care

Where necessary:

- Provide assistance to patients in preparing for the journey (eg, helping with outer garments).
- Remind patients to carry their medication with them, together with clinic documentation (eg, appointment card, doctor's letter).
- Check that household appliances have been switched off, that premises are securely locked on departure and that patients take their keys.
- Provide assistance, with or without the use of wheelchairs/carrying chairs, in and out of the house, hospital departments and vehicle.
- Ensure that patients are not left unattended whilst negotiating steps or stairs and when entering or alighting from the vehicle.
- Be responsible for ensuring that items left on a vehicle by a patient are returned to them within the same working day, if they can be identified, or returned to the (hospital) officer if not identified.

Source: Audit Commission from one hospital trust's agreement with an ambulance service

84. Service quality involves achieving or exceeding targets or standards not just setting them. Systems to ensure this are often weak. Financial arrangements frequently contain no incentives for providers to meet quality standards. Though commissioners may respond to complaints, systematic monitoring of performance is also often poor. Ambulance services often collect quality data – for example, recording when patients are picked up and dropped off from vehicles, in order both to monitor journey times and to compare delivery times with clinic appointment times – but commissioning bodies sometimes take little interest in this.

85. In addition, where service agreements contain different quality standards for different hospital clinics or hospital sites, standard ambulance service quality monitoring systems may not be tailored to reflect these. Other quality monitoring requirements have not always been implemented; for example, at one site visited, the agreement between the hospital and ambulance service included requirements to carry out patient surveys but this had not been done. Elsewhere, an unfilled post meant that an ambulance service did not provide hospitals with any data on quality for six months; the hospitals did not ask for the data or enquire why they were no longer receiving it.

Home-to-school transport and social services transport

‘Pupils need to arrive at school on time, without undue stress from their journey and receptive to learning. The absence of a good transport system can undermine effective learning.’

One county council's best value review, 2001

86. Local authorities are increasingly identifying service quality issues by consulting users, their parents and carers, and schools. They are also using complaint procedures to highlight and then respond to service failures. Consultation often reveals that people regard a service as good if, as well as being safe, it is reliable, and avoids overlong, or uncomfortable, journeys.

87. Home-to-school and social services transport thus often have requirements for reliability and timeliness. The importance of punctuality may vary for different service users – for example, many elderly people living alone may not be concerned by delays in returning home, but other social services clients may become anxious if their routine is upset or if they may be late for attending other activities.

‘Most of us live alone. Why the panic [about what time we get back]?’

Older social services client interviewed during a best value inspection

‘When I was starting [at college] they said be ready at 12.30 and I was sitting there and I had to have my dinner at 11.30. It was a warm day and I was sitting there waiting and waiting and my mum said it wasn't good enough. She rang and they still didn't turn up. I got there and the co-ordinator at college said “Where have you been?” and I said I was waiting for him [the driver]...The college courses I was on were very important – it was important I was there on time.’

Social services client

88. Occasional punctuality problems and late arrivals may be unavoidable, for example, ones caused by unexpected roadworks. But regular late arrival is highly undesirable, as it disrupts clients' day at the centre or children's education. OFSTED, the Audit Commission and the Social Services Inspectorate have, on occasion, identified problems that are adversely impacting on education or care [BOX 0]. Where dedicated transport is being used, punctuality can be monitored directly. Where children are using passes on public buses this can be more difficult. However, persistent problems on specific routes can be brought to the attention of the operator and, where necessary, to the traffic commissioner (if, for instance, an operator repeatedly fails to run registered public routes). In one authority, where a school was experiencing problems on one route, parents monitored delays. These were then reported to the LEA and the operator and, following discussions, punctuality improved significantly.

BOX 0

Transport problems sometimes impact adversely on education or care

'A number of sessions ... begin late due to the late arrival of transport from the feeder schools. This reduces overall teaching and has the potential to reduce attainment.'

OFSTED report on a county council secondary school

'There are persistent and sometimes chronic problems with transport for pupils. Pupils arrive late, and after the start of the school day regularly. This may be anything between five and twenty five minutes after the start of the school day ... it is difficult to make a suitable start to lessons with a whole class until 9.30, when the majority of pupils has arrived ... Some pupils are missing significant parts of their education, that accumulates over time to many days of lost opportunities.'

OFSTED inspection report on a special school

'There has been a high level of frustration for both staff and users due to the unreliability of the ageing council transport. Over the winter, starting problems with the vehicles have meant long delays in users being collected and arriving at the centre. This has played havoc with their daily programme and meant that some users have missed their weekly bathing slot.'

Report on a Joint Review of a Council's Social Services Department by the SSI
and the Audit Commission

89. Some authorities have been slow to set standards. For example, in late 2000 in London, some boroughs did not have formal policies on maximum permitted journey times or punctuality on their special educational needs transport [EXHIBIT 14]. Where standards for maximum travel times had been set, they ranged from as little as 45 minutes, for in-borough journeys in some authorities, to the two hours used by some other authorities for out-of-borough journeys.

90. Service quality also covers softer issues such as journey comfort. Journeys can be uncomfortable if drivers do not show consideration for their passengers and other road users. Users may suffer if drivers repeatedly accelerate and brake sharply, or take corners at speed; lack of care when going over road humps can also be unpleasant. Driver training can address these issues. In winter, clients can also feel uncomfortably cold if all the doors on a vehicle are left open for long periods, for example, while wheelchairs are loaded or unloaded. In summer, they may find the glare of direct sunlight unpleasant. Tinted glass or blinds on vehicles and heating or air conditioning can help. The image projected by the service can also be important – some people may prefer not to travel in vehicles labelled as ‘ambulances’ or which have an institutional appearance. Pick-up arrangements can also be important.

‘I had to walk to the bottom of the cul-de-sac at five to eight and it never came till five past nine and you’d get soaking wet.’

Social services client

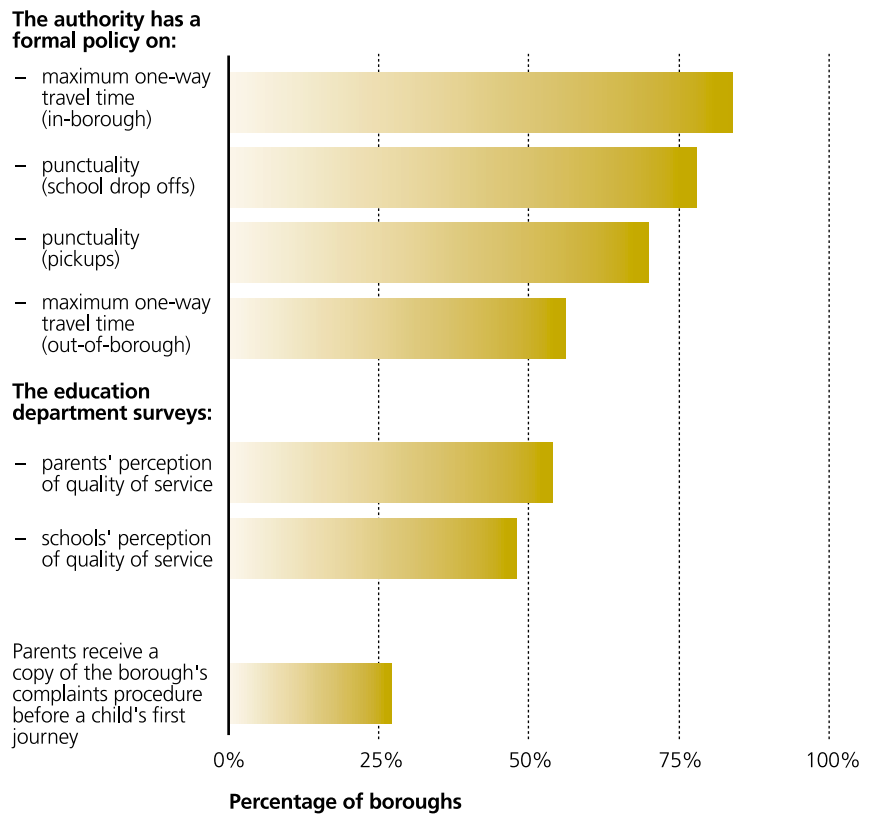
EXHIBIT 14

Service quality for special educational needs transport in London

Some boroughs do not have any formal policy on maximum permitted journey times or punctuality.

Note: Percentages are based on the number of boroughs that provided data in response to each of the questions included in this analysis. This number varied between 25 and 27, as some respondents did not answer all questions.

Source: Audit Commission survey, 2000



91. A pupil or client who does not use English as a first language may prefer to be accompanied by someone who speaks the language that he or she uses at home; sensitivity to religious and cultural needs can also be important. Responding to these needs and concerns will be easier if passenger assistants reflect the cultural and linguistic backgrounds of the children using the service. Recruitment practices that successfully address diversity will help; but changes to job specifications may sometimes be needed, to ensure that passenger assistants include people with necessary linguistic or other skills. Children and adults who use sign language may similarly value travelling with staff who can sign.

92. Best value has helped to redirect focus and emphasis in local government and service quality is becoming increasingly important. But, as in the health service, quality standards, where set, have not always been monitored; and contracts, and service level agreements with ITOs, do not always encourage or reward providers for meeting standards.

Conclusion

93. Non-emergency patient transport, home-to-school transport and social services transport are part of a complex set of transport arrangements. Eligibility criteria vary and do not always treat people equitably. Some users are very satisfied with the service that they receive but others are not. Service standards and quality vary widely. To some extent, these variations reflect the great challenges that health bodies and local authorities face when delivering the services. The next chapter describes these.



3

Delivering the Services

Local authorities and NHS bodies face financial pressures and need to balance costs and service quality.

Local authorities also need to take account of wider transport policies when arranging mainstream home-to-school transport. They and health bodies can make better use of resources without damaging service quality. In particular, there are opportunities for greater co-operation within councils and between councils and health bodies. Local authorities and health bodies also need to respond to change.

94. In delivering transport services:

- There are tensions between the changes needed to improve service quality and customer focus, and pressures on finances and to increase efficiency. Budget-setting for the services could sometimes be improved.
- There is a particular need in local government to take account of wider policies on transport, the environment and health when arranging mainstream home-to-school travel.
- There are opportunities to make better use of resources without damaging service quality.
- There are particular opportunities for better co-operation between different departments in local authorities and for co-operation between councils and the NHS.
- Some of the arrangements for managing service provision could be improved.
- Health bodies and local authorities need to respond to change.

The rest of this chapter discusses these issues.

Balancing costs and service quality

‘If the doctor says they need to see a patient next Friday and transport says they can’t do it and to make another appointment, it’s almost a transport-led service not a patient-led service.’

Nurse, London

95. There is a tension between the changes needed to improve the customer focus and quality of non-emergency patient transport, home-to-school transport and social services transport, and the financial pressures to control expenditure and to increase efficiency. At present, the emphasis tends to be strongly on the latter. However, savings and efficiency improvements have to be balanced against the impact on service quality and on patient- or user-focused service provision. For example, changes to routes and networks that increase provider efficiency – by maximising seat utilisation – may be undesirable if they have an adverse impact on service quality, by increasing journey times.

Financial pressures

96. Ambulance services and hospital trusts report strong internal pressures to control expenditure on transport demand and requirements to meet year-on-year NHS efficiency improvement targets.

97. Local government – particularly county councils when providing home-to-school transport, the largest expenditure area covered by the Commission’s study – buys from a transport market where costs are increasing faster than general inflation. Tender prices for home-to-school transport have increased at above inflation rates across the country in recent years. The Association of Transport Co-ordinating Officers (ATCO) reported, in November 2000, that recently re-tendered school bus contract prices (new prices on existing routes the previous contracts for which had recently expired) were 11.1 per cent higher than the contracts that they replaced. ATCO also reported that authorities would need a 7.4 per cent increase in budget from April 2001 to retain existing levels of school bus services (Ref. 34). Some authorities, such as Staffordshire and Cheshire, have reverted to in-house provision to meet some of their needs.

98. The Office of Fair Trading has successfully acted against two illegal anti-competitive price-fixing arrangements, between contractors bidding for home-to-school work, in Hull and in Staffordshire (Ref. 35). Officers in some other local authorities suspect similar practices but have no firm evidence to demonstrate that this is so.

99. Factors offered to explain increasing costs – by the Government, in its response (Ref. 36) to a report by the House of Commons Select Committee on the Environment, Transport and the Regions (Ref. 37) and by local authority officers interviewed by the Commission – include:

- increases in transport costs, especially drivers’ pay – as unemployment levels have eased, many transport providers have had to increase wages to retain or recruit drivers, but driver recruitment remains a problem, especially in the southern part of England;
- the extension to part-time staff of the same employment rights as full time staff;
- above-inflation rises in fuel, insurance and other vehicle running costs;
- changes to vehicle specifications, as a result of changing seat belt specifications and regulations on how to secure wheelchairs within vehicles – the latter has also tended to reduce the number of wheelchairs carried by each vehicle;
- increased training costs in response to health and safety requirements;
- moves towards smaller vehicles because traffic-calming measures are making it difficult for larger vehicles to collect people from, and deliver them to, addresses in side streets; and

- inclusion policies for the education of children with special needs. Taking pupils to many different mainstream schools can require more, but smaller, vehicles than taking them to a small number of special schools.

100. Financial pressures on home-to-school transport costs have been accentuated by requirements in England to delegate most of the LEA budget to schools; home-to-school transport is the largest cost retained within many LEA central budgets. Rising transport costs, or budget overspends, can, therefore, dramatically impact on other central LEA functions, creating great pressures to control expenditure.

Finance-focused services

101. Though users can see them as essential, managers in the health service and in local government tend to view non-emergency patient transport, social services transport and home-to-school transport as diverting resources from frontline services. Service provision has thus tended to be strongly finance-driven, with service quality and customer care constrained by cost. This helps explain the variations in quality standards, and the lack of emphasis on ensuring that these are met, discussed in the last chapter. In local authorities, the strong cost focus may even influence how councils approach best value. For example, one council visited had not consulted schools in a best value review of home-to-school transport. It was assumed that schools would favour increasing the numbers eligible, when doing so would increase central LEA costs rather than be met from schools' budgets.

Budget setting

'The home-to-school transport budget has been overspent every year since 1994/95. Changes in the duties of the LEA have resulted in a more expensive service, but budgets have not been increased in line with this.'

Officer, London, Audit Commission survey of London boroughs, 2000

The interaction of home-to-school travel and other policies

102. The strongly finance-driven approach to services means that budgeting tends to be top down, not bottom up. Cost versus quality trade-offs, and wider policy issues such as social inclusion and the environmental agenda, are rarely considered. In addition, the process does not always take account of changing demand and service quality requirements, or of cost pressures peculiar to transport. Perversely, these weaknesses mean that, despite the cost control focus, budget over-spends, or in-year budget-crises, are common. Poor in-year monitoring of expenditure is sometimes a further factor in this. More local authorities and health bodies need to improve their analysis of costs and other pressures when setting budgets for social services transport [EXHIBIT 15, overleaf], home-to-school transport and non-emergency patient transport.

103. Carbon dioxide from vehicle emissions contributes to the greenhouse effect and global warming; other pollutants emitted from car exhausts have detrimental effects on air quality. The 1998 Transport White Paper, *A New Deal for Transport: Better For Everyone* (Ref. 38) put forward a vision in which central and local government, transport operators and individual car users and commuters would work in partnership to create an environmentally sustainable and integrated transport system which is accessible to all.

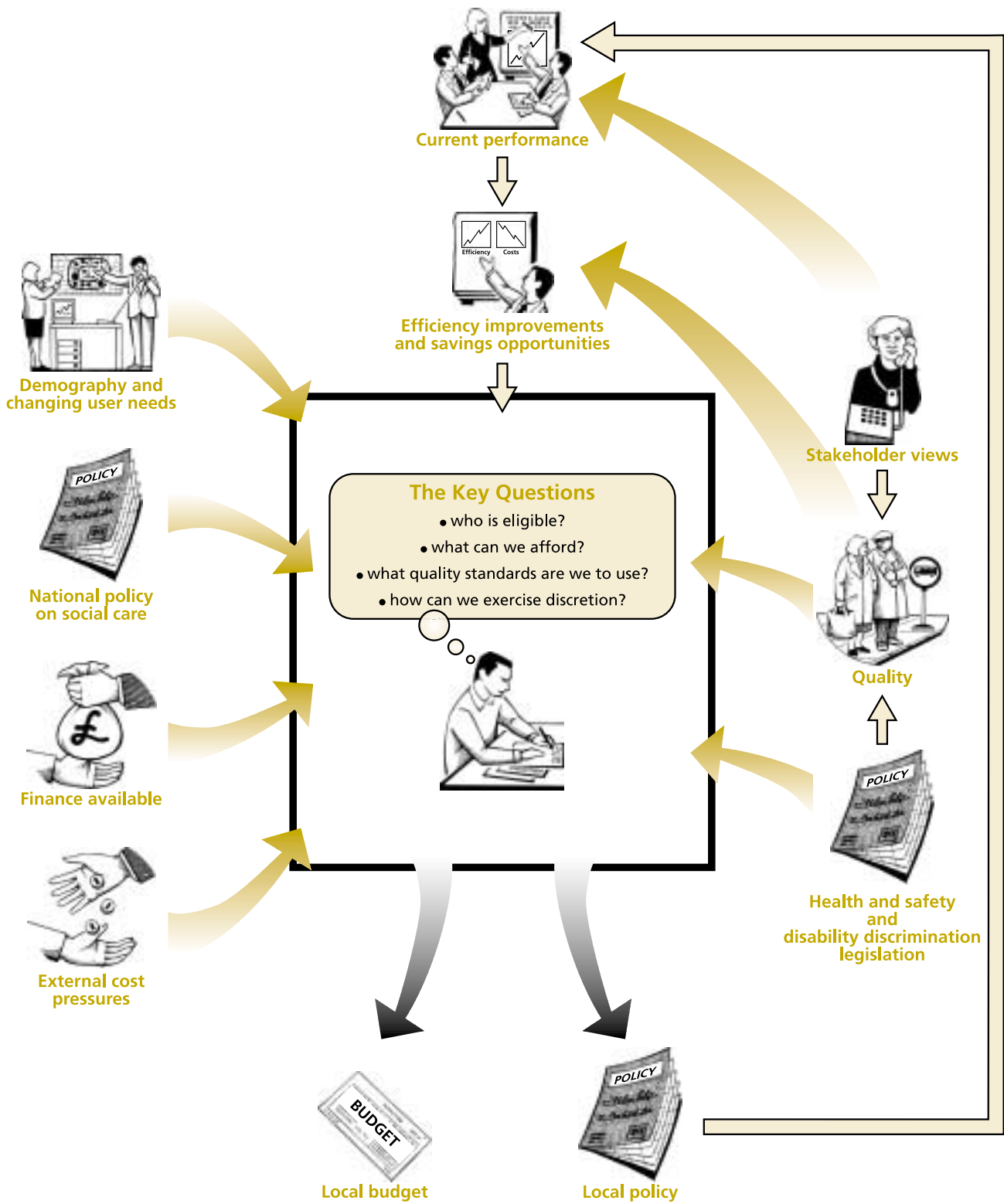
104. The Government is not attempting to reduce or discourage car ownership but to reduce reliance on cars. Examples include revising land use planning and other guidance to encourage town centre and brownfield developments. Improved transport planning through Local Transport Plans, and better bus services that offer an attractive alternative to the car, are a central part of this vision.

105. *From Workhorse to Thoroughbred: A Better Role for Bus Travel* (Ref. 39) followed up the White Paper and set out in more detail how Government saw the role of bus services. ‘Quality partnerships’ between local authorities and bus operators were seen as one important way of making bus services more attractive. Under these arrangements, the operator might, for example, provide new, low-emission buses on a route, and customer-care training for drivers; the authority might provide improved facilities, such as bus shelters, bus lanes and bus priority at traffic lights along that route. The Transport Act 2000 provided legislative underpinning for many of the ideas set out in both the White Paper and *From Workhorse to Thoroughbred*.

EXHIBIT 15

Setting the budget for social services transport

Analysing cost and other pressures can help.



Source: Audit Commission

106. The White Paper saw measures to reduce car-based travel to school as one way of addressing car use. Walking remains the most popular way of going to and from school. Bus travel also remains important, especially for secondary school pupils. But travel to and from school by car – ‘the school run’ – has grown since the 1980s, especially for primary school pupils, and becomes increasingly important the further children live from their school [EXHIBIT 16, overleaf]. This is part of a wider decline in walking that the Government is seeking to address not just on environmental grounds but also because of the detrimental impact on people’s health of the reduction in the exercise that they are taking (Ref. 40).

107. The DTLR and the DfES, assisted by the School Travel Advisory Group (STAG), have been encouraging local authorities and schools to work with parents to reduce car travel, and to promote alternatives such as walking and cycling for shorter journeys to and from school. The Government has encouraged the development of school travel strategies and plans, including a request for local authorities to reflect these in their Local Transport Plans; funding of local authority school travel plan co-ordinators; free consultancy advice to schools; and the publication of best practice guides (Ref. 40).

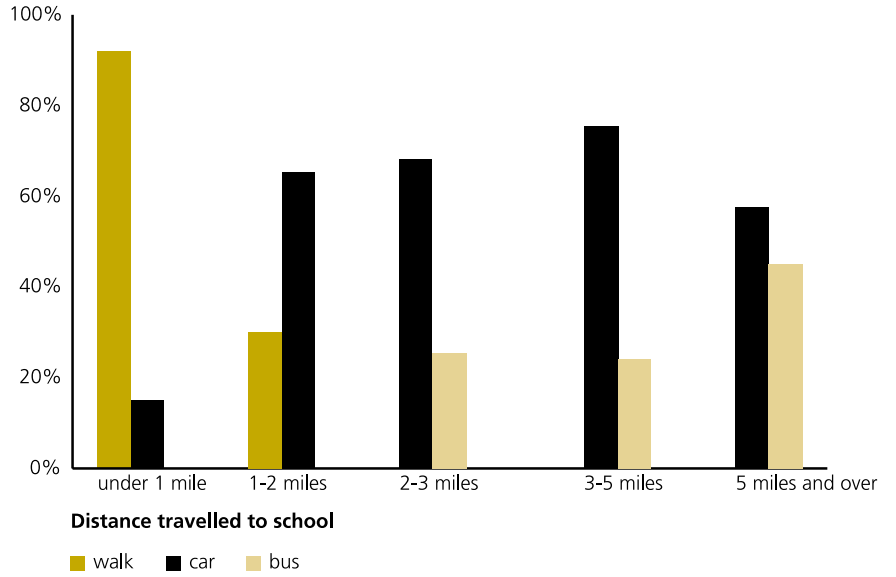
108. Other initiatives include Safe Routes to School, promoted by the charity Sustrans and based upon an idea developed in Denmark, which ensure that the pavements, lighting, road crossings and other features on an entire walking or cycling route to school are safe. ‘Walking buses’ are another initiative – groups of children are accompanied to and from school on foot on regular routes and to a timetable; individual children join and leave the groups at agreed points, at or near their homes, much as they would get on and off a bus.

EXHIBIT 16

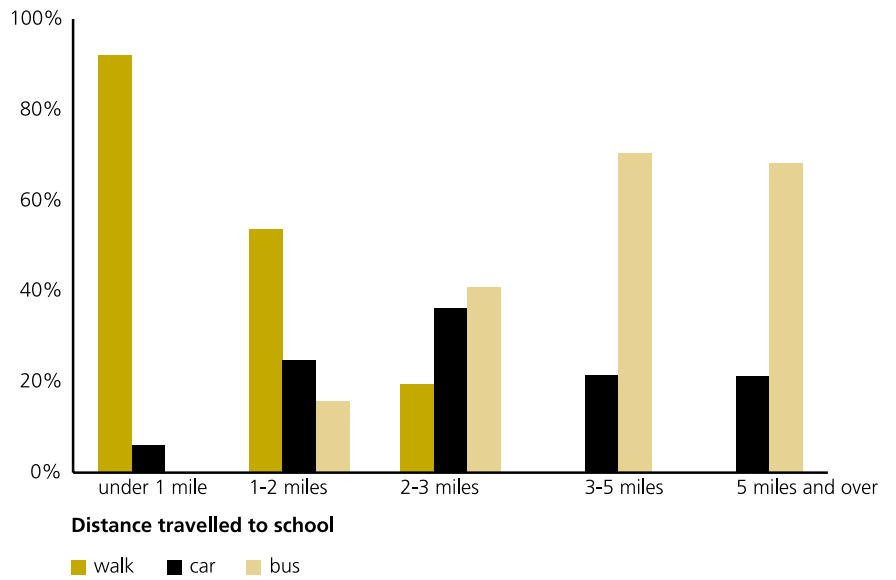
How children travel to school

The distance travelled impacts on the mode of travel.

5-10 year olds
Percentage of children travelling by mode



11-16 year olds
Percentage of children travelling by mode



Source: Audit Commission based on Government travel statistics (Ref. 41). 'Other' modes of travel (including rail and bicycle) have been omitted from the graphs due to the small percentages involved.

109. There are also significant opportunities to increase bus travel as an alternative to the school run. Behavioural problems on school and public transport are, for example, one reason why some parents prefer to take their children to and from school by car, but better bus services could reduce the car mileage associated with the school run (Refs. 30 and 31). The evidence also suggests that more parents would prefer to use this mode if it were available and that some would be prepared to pay, or to pay more, for improved services. The Government has issued *Increasing Bus Use for Journeys to School* (Ref. 42) a best practice guide for local authorities, bus operators and others wishing to address this in children's travel to school.

'I need to make sure that they're safe and I can't rely on the buses I'm afraid.'

'I don't think it's for every child because all sorts of things go on, on school buses.'

'My daughter was bullied on the school bus and that has put her off for life.'

'She hates the bus. All the children smoke...I would rather pick her up.'

Parents

Source: WS Atkins (Ref. 30) and University of Westminster (Ref. 31)

110. Free home-to-school transport to mainstream schools forms a central part of many children's experience of bus travel. Poor quality and experiences in these formative years may create a negative lifelong attitude towards public transport. There is, therefore, a serious discrepancy between the low-cost, poor quality provision of dedicated mainstream home-to-school transport and the efforts that authorities are making to work with operators (for example in a 'quality partnership') to improve public transport.

111. A fully integrated approach to home-to-school travel could continue to support walking and cycling but do more to encourage bus use, for example, by improving the quality of the provision and by providing better supervision on-board. Other options include providing free travel for, or supporting the bus-fare costs of, children travelling less than the statutory distances or travelling to schools that are not their 'nearest suitable' school.

112. The bus operator FirstGroup plans to pilot the use of imported American style yellow buses in the UK. Some local authority transport professionals and others have been critical of the idea, arguing that the vehicles are not suitable for other uses, thus segmenting transport provision, and that they do not meet the requirements of the Disability Discrimination Act. The DTLR has been in discussion with FirstGroup about modifications required to ensure that the vehicles used satisfy UK regulations. The DTLR is also planning to evaluate the pilots [BOX P]. This will throw light on the extent to which the wider use of the vehicles might contribute to home-to-school travel and to meeting the environmental agenda.

BOX P

Evaluating the 'yellow bus' pilots

The DTLR plans to evaluate the pilots, to ascertain:

- the number of children who have transferred to the FirstGroup pilot buses from other modes of travel and the number that would have transferred had there been a seat for them;
- the modes of travel from which children transferring to the FirstGroup pilot buses have come;
- the extent to which transfer has been influenced by cost;
- the extent to which transfer has been influenced by the various features of the scheme other than cost (ie, regular driver, provision of passenger assistant on the bus, bus stop close to home, guaranteed seat with a seat belt, quality of buses, reliability, provision for service following after-school activities);
- whether any children have stopped using the school bus following the introduction of the FirstGroup vehicles;
- parents', children's and local authorities' views of the vehicles;
- views on the accessibility of the FirstGroup pilot vehicles, in order to inform a decision on whether to grant exemptions from the Public Service Vehicle Accessibility Regulations for additional vehicles which may be imported;
- the daily per capita cost of running a FirstGroup pilot vehicle, compared with the daily per capita cost of running a traditional school bus;
- whether there are any differences in attitudes between rural/urban locations, primary/secondary schools and varying socio-economic areas; and
- how the safety record of the FirstGroup pilot vehicles compares with that of the vehicles previously (or traditionally) used.

Source: Audit Commission, based on information provided by the DTLR

...many transport professionals in local government see the legislation on free home-to-school travel as a hindrance to meeting the Government's transport agenda.

113. Budgetary pressures mean that LEAs are understandably unwilling to use education funds to support broader transport policies. The alternative is to provide subsidised public bus routes that serve schools and that are funded from transport budgets. Authorities were constrained in how they approached this by the Transport Act 1985. This still allows them to secure services that would not otherwise be provided but, until recently, included a duty not to inhibit competition when doing so. Many councils believed that this made it difficult for them to arrange public bus services for schools that ran alongside less frequent or poorer quality commercial services serving the same schools. The Transport Act 2000 has improved the position by replacing the duty not to inhibit competition with one to have regard to the interests of the public and of persons providing public passenger services in the authority's area.

114. Nevertheless, the interface between the legislation on public bus services and home-to-school travel remains a difficult one for local authorities. For example, recent counsel's advice to the DTLR suggests that contract home-to-school services that also carry fare-paying passengers (for example, when the local authority is selling spare seats to pupils who are not entitled to free travel) need to be registered as local bus services (even though they are not available to the general public). This has bureaucratic consequences for the operator and also constrains the contractual framework, since local bus service tenders and contracts are subject to different, more stringent, regulations than schools contracts. Authorities thus face either higher costs or abandoning the sale of spare places.

115. Such difficulties help explain why many transport professionals in local government see the legislation on free home-to-school travel as a hindrance to meeting the Government's transport agenda. The law is based on outdated assumptions in which two-parent families are the norm, only one parent works and the other is free to take younger children to and from school. It also dates from a time when road traffic was very much lighter than now and it was more reasonable to expect children to make unaccompanied journeys of up to three miles on foot. Parents are now more concerned about the dangers from road traffic. They also have fears about their children being attacked by strangers during the journey (Ref. 31). Some education professionals also argue that the legislation is outdated, for example because it does not take account of the changing school day.

Service provision

Making better use of resources

116. Local authorities and health bodies have done much to ensure that they use transport resources effectively and efficiently. Nevertheless, there are opportunities in some places for further improvements and savings, for example by:

- **Improving the planning of routes.** Some ambulance services and local authorities still schedule manually. Used appropriately, computer-assisted scheduling systems – geographical information systems and other IT tools – can help to improve route design. They can provide rapid on-screen display of where people live and where they are travelling to, together with route options identified by schedulers, replacing the slow and cumbersome use of paper maps. One local authority visited by the Commission's project team had a geographic information system but had not been using it to help with route planning and scheduling. During the visit, the authority arranged for its schedulers to access the system for the first time. Within minutes, they were identifying inefficiencies and opportunities to rationalise and improve their existing arrangements.
- **Making better use of in-house resources.** Some local authorities and ambulance services can still do more to reach agreement with their staff sides on improvements to working practices and increased flexibility. In one council, a no-redundancy policy meant that the council was arranging routes around driver numbers and consequently was over-resourced with both vehicles and drivers. Some local authorities also have unacceptably high levels of sickness absence.
- **Reviewing the use of taxis and hired cars.** Taxis and hired cars play an important part in meeting needs. They can help to meet difficult-to-predict and low-volume out-of-hours demand for non-emergency PTS. In local authorities, some children's and social services clients' journeys may be so unusual that they are difficult to accommodate economically on a bus route. In addition, some in-year changes in the numbers of children or clients to be carried, and the places they travel between, can be difficult to accommodate within the existing bus network. Lastly, some pupils' and clients' needs or behaviours mean that it is best that they do not travel with others. Taxis and hired cars do, however, have high costs per user journey. Their large-scale use is unlikely to be cost-effective. Spot hire should be avoided wherever possible – prices are likely to be higher and quality of service more variable; it also increases opportunities for corruption. Formal contracts are likely to obtain better prices. And, by guaranteed future work, they may encourage suppliers to invest in training, thus helping to improve service quality. Contracts can include call-off prices for services required at short notice, as well as prices for scheduled work. Local authorities can further exploit economies of scale by co-ordinating purchasing across departments; some are spending many hundreds of thousands of pounds a year in their local taxi and hired-car markets.

- **Periodically reviewing networks in local authorities.**¹ Local authorities work with relatively stable travel patterns. However, though some ad-hoc in-year changes are unavoidable, continued long-term incremental change may eventually create a network that uses resources poorly. Regular re-examination of arrangements, to identify opportunities for rationalisation, is desirable. In home-to-school travel, reviews can be carried out annually in conjunction with planning for the changes associated with the new school year.
- **Greater flexibility when providing non-emergency PTS.** Some commissioning bodies regard their provider ambulance services as inflexible and unwilling to alter service delivery patterns without seeking what they, as commissioners, regard as unrealistic increases in cost. There are widespread difficulties with out-of-hours transport (that is, non-emergency patient transport at evenings and weekends, outside the normal Monday to Friday working week). Demand is increasing with, for example, the appearance of ‘twilight shifts’ for renal dialysis. In urban areas there can be sufficient work to persuade hospitals to fund a 24-hour non-emergency service, especially where, as in Manchester and Gateshead, hospitals are close together and can jointly fund such provision. But this is not being done in all urban areas or in many rural ones. Without adequate out-of-hours arrangements, there may be either bed blockage or the use of emergency vehicles for non-emergency PTS; the latter involves a cross-subsidisation, from emergency to non-emergency PTS, as well as a diversion of resources that may adversely affect emergency response times. Because of this, the London Ambulance Service began to fund dedicated out-of-hours non-emergency PTS vehicles from its emergency response budget in parts of London during 2001.

Improved co-operation

117. Co-operation is one important way of improving efficiency. Options include co-operation within local authorities and co-operation between them and the NHS.

Co-operation within local authorities

118. There are several options:

- **Central transport co-ordination units.** Letting and managing transport contracts involves specialist skills. A number of authorities have therefore created council-wide transport co-ordinating units. Examples include Devon County Council, which has had such a unit since 1986, and Cheshire County Council, where a recent best value inspection found the service to be both ‘good’ and ‘likely to improve’ [CASE STUDY 1, overleaf]. Such central co-ordination can offer economies of scale, which make effective use of technical skills. It also ensures that different parts of an authority do not unwittingly go to the market at the same time, competing against each other for suppliers’ resources and driving up prices.

¹ There is less opportunity for this with non-emergency PTS, where each day’s travel pattern tends to be different and to require an individually designed set of routes.

CASE STUDY 1

Transport Co-ordination Services

Devon County Council

The County Council's Transport Co-ordination Service:

- co-ordinates, manages and administers the provision of home-to-school transport, for both mainstream pupils and for pupils with special educational needs, on behalf of the authority's Department of Education, Arts and Libraries (includes post-16 travel to education);
- provides similar services for the Social Services Department;
- manages and arranges subsidised public transport (bus) services;
- provides support and advice for community transport schemes, working with operators, other public sector bodies and voluntary bodies;
- administers a concessionary fare scheme on behalf of district councils in Devon and for Torbay unitary authority;
- co-ordinates and manages the County Council's vehicle fleet;
- provides identity badges for drivers and passenger assistants; and
- deals with contract compliance, including adherence to vehicle safety requirements and provides driver training.

The county transports about 20,000 pupils and students each day, about 800 of whom attend special schools. Some mainstream pupils travel on public bus (or rail) services, using passes purchased by the Co-ordination Service but most pupils use transport provided by contractors or on council-owned vehicles driven by contractors.

Cheshire County Council

The Audit Commission's Best Value Inspection Service reported on its inspection of Cheshire County Council's Transport Co-ordinating Service in May 2001. The Commission concluded that the service was 'good' and 'likely to improve'.

The Service deals with:

- mainstream home-to-school transport;
- transport for elderly people, people with disabilities, children in care, and children who have special educational needs;
- public transport – supported (ie, subsidised) public bus services, information about public transport, concessionary fares (on behalf of nine district and unitary councils) and rural bus grants; as well as
- school crossing patrols; and
- fleet management.

It arranges transport daily for 24,000 clients, 2,000 of whom are children with special educational needs and 2,300 of whom are social services clients. Children and adults with special needs travel on a mix of in-house and externally provided transport.

The Co-ordinating Service works closely with other council departments and with other local authorities. It had a budget of £23 million in 1999/2000, £19 million of which was covered by service level agreements with the council's Education Department, Social Services Department, other parts of the County Council and other local authorities.

The inspectors found that the service contained good practice and innovation; was held in high regard by its customers; had good comparative performance; and was cost-conscious. It had carried out a thorough best value review, had a track record of innovation and improvement, and worked within the County Council corporate framework for performance review. One example of internal partnership working was the joint work between the client departments (Education and Social Services) to develop a specification for buses for special needs transport.

Central co-ordination allows authorities to offer to tender packages of transport work that cover several services.

- **Co-ordinated procurement.** Central co-ordination allows authorities to offer to tender packages of transport work that cover several services. Contractors can then identify opportunities to share resources across, for example, social services transport and transport for children with special educational needs, and reflect this in their prices. Authorities using in-house providers often achieve the same effect by, as in many London boroughs, allowing one ITO to provide services for both client groups. Costs may then be reduced by pooling spare vehicles, by sharing reserve drivers and by using joint vehicle-leasing or maintenance contracts. In Suffolk, an Education Transport ITO acts as an agent for some social services work via a service level agreement (SLA). Local social services managers – community and residential resource managers in provider units – liaise with transport providers day to day, while Education Transport initiates and manages contracts. In Derbyshire, transport operations remain within separate departments, but savings are achieved by close collaboration between departments and with Community Transport.
- **Operational integration.** As well as jointly procuring transport services, some authorities have operationally integrated transport between some departments or, more rarely, across the entire authority. For example, Lewisham Borough Council’s operational integration of its social services and special educational needs transport services, allows the same vehicles to be used for several types of work [CASE STUDY 2, overleaf]. In Devon, the Transport Co-ordination Service identifies options for co-ordinating arrangements that offer savings both to the authority’s Education Arts and Libraries Department and to its Social Services Department. Another advantage of operational integration is that, as at Lewisham, the same training and standards of care are used when dealing with social services users as for pupils with special educational needs. This can ensure equity for users, for instance, in escorting practices; commonly, authorities that do not co-ordinate social services and special educational needs transport apply inconsistent standards and approaches to accompanying the two client groups.

CASE STUDY 2

Integrating special educational needs transport with other transport operations

Lewisham Borough Council's Passenger Services unit is an ITO that provides transport for the Council's Education and Social Care and Health (ie, Social Services) Departments. The Education work is all for children with special educational needs. Passenger Services also provides non-emergency patient transport for University Hospital, Lewisham and is providing the local Dial-a-Ride service as a pilot for the Commission for Accessible Transport. It also provides some transport directly to

individual schools (eg, for school trips) with individual schools exercising their freedom of choice, under local management, about whether to use Passenger Services or another supplier. Passenger Services carries over 1200 people a day, using vehicles ranging from estate cars to 45-seat coaches.

Lewisham integrated its transport arrangements for its then new Education Department and its existing Social Services Department, when it became a local education authority in 1990, on abolition of

the Inner London Education Authority. The times of Social Services day centre sessions were changed where necessary. During the school year, vehicles pick up children and deliver them to school before then carrying social services clients. The reverse happens in the afternoon. The same drivers and attendants (ie, passenger assistants) work on the two runs, applying the same working practices and standards of care to both client groups.

Source: Audit Commission fieldwork

119. While in efficiency terms a good idea, operational integration of the delivery of special educational needs and social services can create dilemmas about the trade-offs between efficiency and service quality. For example, the times at which clients leave the day centre have to dovetail with the afternoon special school run, reducing the ability of the centre's staff to adjust their programme of activities during the day. It can also lead to interdependencies that may reduce flexibility. For example, a delay in a morning special school run, caused by heavy rush-hour traffic, might mean that a social services run starts late and that social services clients arrive late at a day centre.

120. Loss of flexibility means that co-ordination is sometimes unpopular with frontline social services staff, compared with arrangements where vehicles are permanently allocated to individual centres. When a co-ordinated service is provided in-house, reductions in vehicle use by one department – for example, social services – may not deliver significant changes to the authority as a whole – for example, if the council still needs the vehicles for home-to-school work, and thus still has to meet their full cost from somewhere within its budgets after social services use decreases.

121. Despite this, wider co-operation within local authorities brings many advantages that are not yet being grasped everywhere. Some of these can be obtained by other routes in the former metropolitan counties. Metropolitan district councils' use of their local PTEs to organise mainstream home-to-school transport offers similar advantages. PTEs are well placed to maximise efficiency and exploit economies of scale to negotiate for bus passes with operators (with whom they already negotiate on concessionary fares schemes); to integrate home-to-school transport with the public bus network (as PTEs already arrange subsidised, socially necessary public services), and to let contracts for dedicated school transport (as PTEs already purchase subsidised public services from operators).

Co-operation between local authorities and the NHS

122. Co-operation between local authorities and the NHS offers another way forward but is comparatively rare. Examples include Suffolk County Council, which has achieved 'Beacon' status for co-operation with its local health authority. Suffolk is working to an integrated plan for health and social services, which has implications for transport. Jointly funded projects include a day centre for older people located in a community hospital with ancillary healthcare provided on site. Organising transport is the responsibility of the day centre manager and includes deployment of non-emergency PTS ambulances and community buses. Co-ordination of transport provision has also been carried out in Staffordshire [CASE STUDY 3].

CASE STUDY 3

Integration of transport between social services and the NHS: Staffordshire

One hospital in Staffordshire has opened a day centre and rehabilitation facility jointly with the Social Services Department. About 60 people attend each weekday for physiotherapy and other services. Referrals are accepted on a quota basis from both social services and hospital doctors, with the majority referred by the NHS to assist in post-operative recovery. The centre manager organises transport for all those coming in for daycare. Most of this is provided on social services wheelchair-accessible 'blue ambulances'. A small number of users come in taxis provided by the NHS – they are largely people who cannot easily be accommodated on the blue ambulance routes.

Source: Audit Commission fieldwork

123. Cross-sector co-operation is being developed in Worcestershire, by the local Health and Transport Partnership [CASE STUDY 4]. Other options include, in suitable cases, use of social services transport rather than NHS non-emergency PTS for the discharge of elderly people from hospital. Discharges can often involve occupational therapists and social workers and preliminary discharge planning meetings at the client's home. Problems with transport can both delay discharge, leading to bed blocking in the NHS, and waste social workers' time.

CASE STUDY 4

Integrated transport services:

Worcestershire

A joint Worcestershire Health and Transport Partnership was formed in 1999 at the instigation of the County Council and Health Authority. By working together the partnership has substantially improved transport services in the area with significant funding being provided by both the County Council and the Health Authority. Changes in the acute health sector provided the catalyst for a stakeholder conference in November 1999 which identified the need for a partnership approach. Partners recognised that in some parts of rural Worcestershire there was a dearth of transport provision.

The joint group now includes a wide range of public, private, health and voluntary sector organisations including:

- Worcestershire County Council;
- Worcestershire Health Authority;
- Hereford and Worcester Ambulance Service;
- Wychavon Primary Care Group;

- Hereford and Worcester Chamber of Commerce;
- the local Community Council (representing community transport and the voluntary sector);
- Kidderminster and District Community Health Council; and
- bus operators.

The joint group was set up to develop a co-ordinated approach to transport which:

- produces harmony and synergy of Health and Local Government strategic policy;
- meets the objectives of the NHS Plan to promote partnership and collaboration;
- reduces duplication;
- achieves efficiency savings or service improvements;
- establishes a call centre for Worcestershire that manages community transport requests;
- provides access to premises which maintain health, which is recognised as crucial in terms of rural health; and

- achieves integration, enabling current organisational barriers to be addressed.

Consultants act as facilitators. Although the County Council and the Health Authority in Worcestershire were already pursuing joint working, their common interest in passenger transport was cemented by the need to consider access to hospital facilities. This has focused attention on how the route network can provide direct access to hospital sites. The Transport and Health Partnership has had initial discussions with Hereford and Worcester Ambulance Service to investigate closer working, with potential links between social services transport, non-emergency PTS, and community transport. Worcestershire's Local Transport Plan has been developed in partnership through the Worcestershire Transport and Health Group. As an example of joint working with health, school nurses are being used to monitor the effectiveness of school travel plan initiatives.

Source: Audit Commission fieldwork

Managing service provision

124. Local authorities face a number of challenges in successfully managing, organising and providing the services. Relationships between the policymakers and budgetholders, and the organiser and provider, are sometimes blurred when social services and special educational needs transport are provided in-house, with the ITO fulfilling the roles of both organiser and provider. This creates the danger that the client departments (Education and Social Services) may not receive independent professional advice about the management or cost-effectiveness of transport. The absence of a clearly identified transport organiser, who is supervising and managing performance for the client department, also means that the client departments can sometimes be insufficiently aware of performance and service quality. This is not to say that, when provision is in-house, there should always be a separate full-time transport organiser role, separate from an ITO. But client departments should ensure that they specify the information which they require, that they receive it, and that they have confidence in its accuracy.

125. Some local authorities using external suppliers find it difficult to enforce all of their contract conditions successfully. This partly reflects the challenge of finding financial arrangements that provide contractors with realistic incentives for meeting all of an authority's requirements. The challenge is compounded when a dominant local supplier provides the service. The final sanction for failure to comply with the contract – contract termination – may cause the authority's costs to rise if an alternative supplier's vehicles need to travel to the area before beginning work. As a result, termination is used only in extreme cases, such as persistent use of unroadworthy vehicles.

126. There are similar issues in the health service. Commissioning bodies have often managed non-emergency PTS from within their corporate services or facilities management functions. Commissioners often rely on the integrity of provider ambulance services, as part of the NHS family, to adhere to safety and staff competency and to training requirements set out in service agreements; there is frequently no independent assurance that these requirements are being met. In addition, agreements commonly lack financial incentives to encourage ambulance service trusts to meet standards. Although private and voluntary sector suppliers exist, some hospital trusts feel that they have little realistic option other than to use their local ambulance service.

Responding to change

127. Local authorities and health bodies need to respond to change. Public services are aiming to become increasingly customer and user focused. Local authorities are expected to engage with users when reviewing services under the best value performance management framework. For example, fair access to patient-focused services is a central theme in *The NHS Plan* and in the equivalent proposals for Wales [BOX Q, overleaf]. Users' expectations about both the availability and the quality of the transport needed to allow them to access services may well rise in response to this agenda.

BOX Q

Increasing user and patient focus

The *Modernising Government White Paper* (Ref. 43) states:
'... we have three aims in modernising government...[the second of which is]...Making sure that public service users, not providers, are the focus, by matching services more closely to people's lives.'

The Welsh Office White Paper *Local Voices* (Ref. 44) emphasises:
'public services need to be responsive to the needs of the citizens, not the convenience of service providers.'

DETR *Circular 10/00, Local Government Act 1999: Part 1 Best Value* (Ref. 45), states:
'[Best Value] Reviews will need to...engage with users and potential users of services. A customer focus to Reviews is essential.'

National Assembly for Wales *Circular 14/2000* reinforces the messages of the White Paper *Local Voices* and adds (Ref. 46):
'The value of a service cannot be judged without learning from the perceptions of direct, and potential, service users, local citizens and taxpayers, employees and Trades Unions, local businesses and other partners, including the voluntary sector.'

The NHS Plan (Ref. 10) states:
'The NHS will work together with others to ensure a seamless service for patients...The health and social care system must be shaped around the needs of the patient, not the other way round.'
'Patients should have fair access...wherever they live.'
'Members of the public said that they wanted to see better transport and access to services...'

Improving Health in Wales (Ref. 11) states:
'Within the next five years, the hospital service in Wales should offer:...a service that is patient focused and designed with their needs in mind...NHS Wales, operating in this new context will...ensure equitable access to effective and appropriate healthcare according to need.'

Source: Audit Commission

Changes in health and social care

128. Changes in the way health and local social services are provided, and joint commissioning of health and social care, will also present challenges. Health and social care are becoming increasingly person centred; joint commissioning of health services and social care, and the pooling of budgets, is expected to expand. These changes will affect when people travel to services, where they travel to and from, and who organises and provides their transport. The full impact is not yet clear but is likely to add to the pressure for co-operation and co-ordination on social services and health transport. It is also likely to require greater flexibility in transport arrangements with an increased emphasis on smaller vehicles – for example, cars and minibuses rather than coaches for social services transport – and on transport outside the (Monday to Friday) working week.

129. Structural changes in the health service will add to the challenges. In England, Primary Care Trusts (PCTs) are expected to become the lead NHS organisations for planning and securing all health services and health improvement at the local level. They are likely to assume the responsibility for securing the provision of patient transport services (Ref 47). The *National Service Framework for Older People* (Ref. 48) reveals some of the implications of this package of measures for services for older people, one important group of social services clients and users of non-emergency PTS [BOX R]. Other national service frameworks, may also have implications for transport. For example, renal patients and their advocacy organisations argue that transport arrangements should feature strongly in the national service framework that is being developed for renal patients.

BOX R

The National Service Framework for Older People

The National Service Framework for Older People (Ref. 48) states:

'Person centred care will be supported by newly integrated services. This will ensure a well co-ordinated, coherent and cohesive approach to assessing individual needs and circumstances, and to commissioning and providing services to meet them...

Person-centred care needs to be supported by services that are organised to meet needs. The NHS and councils should deploy the 1999 Health Act flexibilities to: establish joint commissioning arrangements for older people's services, including consideration of a lead commissioner and the use of pooled budgets...

The 1999 Health Act placed a duty of partnership on health authorities and councils (social services, housing and other council services) and provided for new flexibilities through pooled budgets, joint/lead commissioning and integrated provision, as well as money transfer powers.'

Source: Audit Commission

130. In Wales, transport has been recognised as important to the new pattern of provision. Health authorities are to be abolished and Local Health Groups (LHGs) have been established within each area to provide a local focus for the development and improvement of health services. They are expected to play a major role in commissioning for health services but it is, as yet, unclear what role they will play in commissioning PTS. Here too, joint working between NHS and local authorities is seen as central [BOX 5].

BOX 5

Changes in Wales

Improving Health in Wales (Ref. 11) states:

'We will see an overall reduction in the number of traditional hospitals over the next generation but with commensurate development of radical new forms of local provision. Where specialist services are provided remotely we will look to develop new transport facilities and overnight accommodation...

Local Health Groups will have an advanced role in commissioning health and health-related social care services. They will lead in achieving effective local joint working across the statutory and non-statutory sectors, so as to develop strong community based health and social care services. They will increasingly work within and across wider geographical areas...

The challenges which this Plan address, are the major business of NHS Wales over the next five to ten years. In order to re-focus on these vital roles, the health service will work more closely with its partners in local government and other sectors. Without this collaboration, the NHS will fail to fight health inequality and ill health and those factors external to the NHS that impact on them. Failure is not an option. Joint working is an essential plank of renewing the NHS.'

Source: Audit Commission

131. Other changes in *The NHS Plan* (Ref. 10) and *Improving Health in Wales* (Ref. 11) have further implications for the delivery of non-emergency PTS and on how performance is specified and monitored. The planned increase in specialisation by hospital trusts and increased delivery of some health services at local health centres and general practices will also impact upon travel and transport requirements. Block booking of appointment times will become less common as, in England, patients book individual appointment times.

132. In addition, amalgamation of ambulance service trusts may continue. Some ambulance service trusts previously formed in this way are rolling forward different pricing models (inherited from predecessors) in different service agreements, without amendment to reflect the new overheads bases created by the mergers. These arrangements are unlikely to be recovering full costs from each hospital trust for which the service is providing non-emergency PTS. They therefore contravene NHS costing requirements (Ref. 49). This problem is increased where emergency services are cross-subsidising non-emergency PTS. Any future amalgamations will need to avoid these mistakes.

Changes in home-to-school transport

‘...transport to and from school makes both close working (with parents) and running activities outside lessons a challenge for the school.’

OFSTED Inspection report on one primary school

133. Local authorities’ home-to-school transport arrangements will also need to change. Inclusion in mainstream schools, and the requirements of the Disability Discrimination Act to provide accessible vehicles, will alter transport arrangements for children with special educational needs. The planned extension of specialisation in secondary education in England set out in the September 2001 White Paper *Schools Achieving Success* (Ref. 50) will also require changes to home-to-school transport.¹ So will the increased role of after-school activities in both England and Wales [BOX 5, overleaf], where transport already sometimes constrains what can be done.

¹ The National Assembly for Wales’ White Paper: *The Learning Country* (Ref. 51) does not contain equivalent proposals.

BOX T

After-school activities

In England, the DfES proposes (Ref. 50):

'As resources allow, we need to widen opportunities for primary children so that they all benefit from a broad and rich curriculum and a variety of extra-curricular activities. We want all children to have more opportunities to learn music, PE, sports and a foreign language. Over time, all primary pupils who want to will be able to learn a musical instrument. As the numbers of sports colleges and sports co-ordinators are increased, they will become two important means of offering schools the support necessary to implement our promise that all children will have two hours of high quality PE and sport each week within and beyond the timetabled curriculum. And we will continue to promote the increases in after-school activities that more than two-thirds of schools have made in the last four years...

'We are extending opportunities for children to be involved in sport,

adventure, art, music and drama within and outside the school day...

'There will be a programme of in-and-out-of-school learning and teaching, (for 14-19 year-olds) including mentoring and master classes and there will be work with parents and families...

'Many schools already recognise the benefits for them and their communities of providing additional services to their pupils, pupils' families and the wider community. Most schools already provide some before or after-school study support; some provide space for sports or arts activities, community groups or Internet access; others work closely with other public bodies to provide integrated services such as health services, childcare or adult education. We shall legislate to make sure that there are no barriers to schools developing these innovative approaches. We will establish pilots to test out such 'extended schools' and generate examples of good practice. And

where schools have already demonstrated the advantages of this approach we will help them develop further to become Centres of Excellence, and celebrate their achievements.'

The National Assembly for Wales states (Ref. 51):

'We want to see families supported during and outside the school day...with careful management and the responsible involvement of professional staff this could also extend the life of the school to embrace breakfast clubs and a wide range of out of school hours, cultural and sporting activities. We believe that there should be a prospectus of such activities for every child at school in Wales, possibly incentive or credit based, covering the vacation period also'.

Source: Audit Commission

Conclusion

134. As this chapter has shown, local authorities and health bodies face a daunting array of challenges to providing efficient user- and patient-focused transport services. Many have responded well to these challenges and there is much good practice that others can emulate, but there are also significant weaknesses and opportunities for improvement. The next chapter therefore discusses the action needed from central and local government and health bodies to bring about those improvements.



4

The Way Forward

Central government should improve the framework within which local authorities and health bodies operate, but local authorities and health bodies can also take action to improve transport services.

Action by central government

135. This chapter describes:

- what central government can do to improve the framework within which local authorities and health bodies work;
- action that local authorities can take now, within the existing legal framework; and
- action that health bodies can similarly take within current circumstances.

136. Central Government and the National Assembly for Wales should recognise the need to treat travel to NHS services, including travel to services delivered by GPs and at medical centres, as an integral part of fair and equitable access. It should offer advice and guidance on transport and travel to health services that reflects the expected changes in their delivery. It should also clarify criteria for free non-emergency PTS, and what it sees as the role of voluntary hospital car schemes and dial-a-ride bodies in travel to health facilities, in order to ensure that people are treated equitably. It should review the Hospital Travel Costs Scheme in the light of these decisions. The Government should make any necessary funding adjustments, to ensure that everyone has the means, and can afford, to travel to and from NHS services without detriment to their health, and to ensure that journeys meet reasonable patient expectations of ease and comfort. It should also give more consideration to the implications of PCTs assuming responsibility for commissioning non-emergency PTS in England. In Wales, the National Assembly for Wales should similarly consider the impact of structural changes in the NHS on responsibilities for commissioning non-emergency PTS.

137. The Government should also more fully align the provision of free home-to-school transport within its wider environmental, transport, school travel and health and fitness policies. It can build on existing initiatives and data from the ‘yellow bus’ trials, but should also review the legislation on free home-to-school travel [BOX U]. In doing so, it should also take account of the findings of the DfES’ work on travel to post-16 education. It should experiment with improved supervision on home-to-school transport to address vandalism and bullying.

138. It should also set, or encourage local authorities and health bodies to develop, core standards for: home-to-school transport; social services transport; and non-emergency patient transport. This will help to remove the current variation in quality and also make it easier for authorities and health bodies, and their providers, to co-operate with each other when providing transport. The recommendations on pages 88 to 90 set out these ideas, and their benefits, more fully.

BOX U**Reviewing the legislation on free home-to-school travel****Options that can be considered include:**

- altering the statutory distance criteria – possibilities include:
 - altering the age at which the three mile test applies, to reflect the age at which children usually transfer from primary to secondary education and to remove anomalies when children of different ages from the same family attend the same primary school;
 - extending the current statutory criteria to denominational schools and other travel to schools that are not the 'nearest suitable' (for example, where parental preference has led to a child attending a school other than the nearest suitable one) – the current arrangements may discriminate against poorer families that wish to exercise their right of choice;
- further altering the Transport Act 1985, so that local authorities can even more easily provide home-to-school bus services that could be used both by children travelling for free and by those paying fares;
- setting core standards for free home-to-school travel that have to be met from within LEA budgets but that allow authorities to top-up these funds, to provide a higher quality of service, from within their transport budgets; and
- transferring responsibilities, wholly or in part, from LEAs to local transport authorities – for example, LEAs might retain responsibilities for assessing whether children who have special educational needs should receive free transport and for then arranging the transport; but otherwise the provision of free home-to-school transport would become a matter for local transport authorities.

Outside London and the former metropolitan counties, the same local authorities – county councils and unitary authorities – act as both the LEA and the transport authority. The last two options would thus involve an adjustment to funding streams within authorities. But in London, they would involve transfers of responsibilities and funding streams between the borough councils and Transport for London; and in the former metropolitan counties, this would involve changes between the metropolitan borough councils and Passenger Transport Authorities.

Source: Audit Commission

RECOMMENDATIONS



Action by central Government

CENTRAL GOVERNMENT SHOULD:	THIS WILL:
<i>Obtain and respond to users' views on travel to NHS services</i>	
Include views on transport in national surveys of patients' perceptions of the NHS	Inform decisions about transport and travel arrangements and standards for non-emergency PTS
Set national standards for non-emergency PTS performance, that reflect patients' requirements and experiences, and arrange for details of performance to be published both nationally and locally	Raise the profile of non-emergency PTS and ensure that commissioning bodies and providers pay more attention to service quality issues
Encourage NHS bodies to examine when it is appropriate for patients to travel to services and when it is more appropriate for services to be brought to them. They should appraise how patients are to reach services with partners, including local authorities and community and voluntary groups. This should cover travel to GP and other services as well as to hospitals	Improve access by helping to ensure that people are able to reach health services
Require that health and social services bodies consider transport issues when considering the location of, and access to, services	Ensure that transport costs are considered when decisions about location are made and help health and social services bodies to make better decisions on access and location
<i>Clarify the role of and entitlement for non-emergency PTS</i>	
Review entitlement to non-emergency patient transport in the NHS, making any necessary funding adjustments. Revised guidance might:	
<ul style="list-style-type: none"> • extend current free provision to the levels found where the guidance is currently interpreted liberally; and/or 	Improve equity, ensuring that no current users lose out while improving access for others. This will also resolve the anomaly where patients with similar conditions and in similar personal circumstances travel free in some places but are asked to pay in others
<ul style="list-style-type: none"> • extend eligibility for free non-emergency PTS to cover travel to services delivered at local medical centres and GP practices; or 	Reflect changing patterns of provision
<ul style="list-style-type: none"> • take a more restrictive but equitable approach to eligibility for free travel. If this approach is taken, the Government should identify how those who have been newly excluded because of the change, but who have a social need for free or reduced cost travel, are to get to hospital. This might involve re-appraising the role and funding of voluntary hospital car schemes as well as of publicly funded dial-a-ride schemes and other voluntary sector provision; and 	Reduce costs to the NHS. Identifying and paying for alternatives will ensure that current users do not lose out while improving access for others. It may increase expenditure elsewhere in the public sector if demand for other types of support for travel increases in consequence

RECOMMENDATIONS



Action by central Government (continued)

CENTRAL GOVERNMENT SHOULD:	THIS WILL:
<ul style="list-style-type: none"> set out more clearly when the NHS can charge patients and what that charging regime should be 	Again address equity and fairness issues, resolving the anomaly where patients with similar conditions and in similar personal circumstances travel without charge in some places but are charged in others
Review the role of the Hospital Travel Costs Scheme in the light of other changes and consider whether the scheme should be better publicised	Ensure that the scheme plays an appropriate role in revised arrangements for travel to health services
<i>Help to improve how non-emergency PTS is commissioned and delivered</i>	
Set out explicitly how it expects transport to health services and social care to be dealt with by PCTs in England and health bodies in Wales and under joint commissioning	Ensure that transport and access issues are not overlooked as new approaches to healthcare, and supporting organisational structures, develop
Encourage the application of a standard contract framework for non-emergency PTS within which individual health bodies can incorporate their local patient-centred requirements. For example, standard clauses might appear in a fixed order, and reflect core standards set by government; other parts might enable the local setting of times the service is to be provided, target arrival times and times on vehicles	Reduce replication of effort in the health service while also allowing local flexibility and adaptation
<i>Further integrate free home-to-school travel and wider transport policy</i>	
Review the legislation on entitlement to free home-to-school travel	Offer opportunities to create arrangements that more closely reflect current family circumstances, working patterns, road traffic levels, road safety and other parental safety concerns. It also offers opportunities for better integration with wider transport policies
Build on existing initiatives, such as safe routes to school, to integrate home-to-school travel with wider transport policy and initiatives	Continue and expand existing work to reduce car dependency and to improve health through increased walking and cycling
Use the DTLR's evaluation of the 'yellow bus' pilots to provide further information on the impact on home-to-school travel patterns of changes to entitlement to free travel and the ways in which that travel is provided.	Provide data to inform the debate on, and decisions about, changes in the legislation on home-to-school travel
Experiment with increased supervision on mainstream home-to-school travel	Reveal whether this can successfully address vandalism and bullying

cont./

RECOMMENDATIONS



Action by central Government (continued)

CENTRAL GOVERNMENT SHOULD:	THIS WILL:
<i>Improve standards and quality of service</i>	
Set, or encourage the development of, core standards for:	
<ul style="list-style-type: none"> mainstream home-to-school transport (for example vehicle quality and safety, driver training and screening, seatbelting, escorting and supervision) 	Provide local authorities with a set of core standards, helping to resolve the tensions between quality of service and budgetary constraints. It will also provide parents and carers with reassurance about safety and service quality
<ul style="list-style-type: none"> providing passenger assistants for special educational needs and social services transport (when to provide passenger assistants, their training and screening) 	
<ul style="list-style-type: none"> vehicle quality and safety and driver training and vetting on SEN and social services transport 	
<ul style="list-style-type: none"> the provision of appropriate information to drivers and passenger assistants about children's and social services' clients conditions and needs 	Clarify the position on release of appropriate information This will help local authorities meet their health and safety obligations towards clients. It will also help to address drivers' and passenger assistants' concerns that they sometimes lack information and would not know how to respond in a medical emergency
<i>Encourage co-operation and partnership</i>	
Encourage co-operation and sharing of resources between local authorities and health bodies	Offer opportunities to improve services and to make efficiency savings that do not compromise customer care and patient focus
Seek, where appropriate, to apply similar standards across social services transport and non-emergency PTS. This should include, where possible and appropriate, similar approaches to vehicle quality and safety and to the application of the Care Standards Act 2000	Address similar issues as core standards for home-to-school transport. It will also facilitate co-operation and sharing of resources between local authorities and health bodies

Source: Audit Commission

Action by local authorities

139. Although changes to the framework within which they work will help local authorities further to improve arrangements, there is much that councils can do within the current framework. This involves:

- taking an holistic view of arrangements;
- emphasising transport's importance in fair access to customer focused services;
- co-operating with others;
- ensuring the safety of passengers, drivers, passenger assistants and other road users;
- setting quality standards based on consultation with users and other stakeholders;
- ensuring that those standards are met; and
- managing finances effectively to avoid budget overspends.

The recommendations overleaf summarise these points.

140. The Commission's separate handbooks on special-educational needs transport, mainstream home-to-school transport and social services transport (Refs. 3, 4, 5) will give more advice. They include detailed self-assessment checklists and case studies to help officers to identify strengths and weaknesses, and to make improvements, in their authorities' arrangements.

RECOMMENDATIONS



Action by local authorities

LOCAL AUTHORITIES SHOULD:	THIS WILL:
<i>Improve user-focus</i>	
Consult with service users and their parents/carers and with other stakeholders such as schools and social services centres	Identify whether current arrangements meet user needs and, if they do not, what improvements are needed to create quality, user-focused arrangements
Ensure that services meet health and safety and other legal requirements and also reflect the results of consultation. (Councils should work to national quality standards once these have been set by central Government, enhancing these locally if they choose, so that they reflect local needs and priorities)	Help to ensure that services are safe and meet users' needs and expectations
Work with schools and transport providers to address vandalism and bullying on mainstream home-to-school transport, considering whether it is necessary in appropriate cases to place passenger assistants on vehicles	Reduce vandalism and bullying, making bus-based travel to school more attractive to pupils and parents. This will reduce operators' losses to vandalism, and so help to control contract prices. Improved pupil behaviour will also make driving school buses less stressful, helping to address driver shortages and associated wage pressures
Ensure that drivers and passenger assistants are properly trained and screened	Help to meet health and safety obligations and improve customer care
<i>Take account of the wider policy context</i>	
Examine arrangements in the context of wider policies on access to, and the location of, education facilities and social services, when carrying out best value reviews	Ensure that best value reviews are not focused narrowly on technical aspects of transport but that they also address fundamental questions about why transport services are needed and about who is to use them
Consider policies and arrangements in the context of social inclusion, wider environmental policies, broader transport policies and the health and fitness agenda	Integrate approaches with broader transport and travel policies
<i>Work with others</i>	
Consider whether there is scope to improve access, efficiency, effectiveness and customer focus, for example by working in partnership. Options include greater co-operation across departments within the authority, working with PTEs (in the metropolitan areas), with community transport bodies from the voluntary sector and with health bodies	Identify opportunities to provide customers with integrated, user-focused services or to use resources more efficiently
<i>Review funding</i>	
Set realistic budgets that reflect demand and the authority's service standards, and monitor expenditure regularly and effectively	Take account of service standards when setting budgets and reduce the likelihood of budget overspends
<i>Improve efficiency</i>	
Review the use of IT, route planning and scheduling and the use of taxis and hired-cars	Release resources to fund improvements in quality

RECOMMENDATIONS



Action by local authorities (continued)

LOCAL AUTHORITIES SHOULD:	THIS WILL:
<i>Improve how the services are managed</i>	
Clearly delineate transport roles, especially when transport is provided in-house	Help ensure that client departments are setting and monitoring performance against quality standards. It will also help with budget setting and monitoring
<i>Monitor performance more effectively</i>	
Use contracts or service level agreements that encourage service providers to meet and exceed safety and quality standards	Help to ensure that safety and quality standards are met
<i>Plan for change</i>	
Review how transport requirements and funding need to change in response to the challenges ahead	Ensure that transport arrangements respond to increased joint commissioning of health and social care, to other changes in social care (such as individually designed care packages) and to changes in education (such as greater specialisation by schools and a greater emphasis on after-school activities)

Source: Audit Commission

Action by health bodies

141. Health bodies can similarly do much, within the current framework, to build on existing good practices to deliver effective, patient-focused transport services. The recommendations facing set out the main steps to take. Here too, improvement involves an holistic, co-operative and client-focused approach that pays proper attention to service standards as well as to finance and cost. The Commission's guidance on non-emergency patient transport (Ref. 6) will offer more detail and includes self-assessment checklists and good practice case studies.

RECOMMENDATIONS



Action by health bodies

COMMISSIONING BODIES SHOULD:	THIS WILL:
<i>Improve patient-focus</i>	
Treat transport arrangements as central to access to services	Help to meet the access requirements in <i>The NHS Plan</i> and <i>Improving Health in Wales</i>
Treat appropriate provision of free transport as part of the package of healthcare	Improve patient-focus and reflect the requirements of the current guidance
Publicise the Hospital Travel Costs Scheme adequately	Implement current guidance
Survey patients' views regularly. Also survey medical staff to obtain their views about non-emergency PTS	Identify whether current arrangements meet patients' needs and, if they do not, identify what improvements are needed to create quality, patient-centered arrangements
Review quality standards after consultation with patients	
Revise quality standards where necessary, to reflect those views, and publicise them locally	Help to ensure that services meet patients' needs and expectations
Monitor performance and publicise how it compares with standards	
Use agreements/contracts that encourage and reward achievement of standards	Help to ensure that safety and quality standards are met
<i>Improve the status of non-emergency PTS</i>	
Treat non-emergency patient transport as a core part of the NHS	Recognise that, currently, free non-emergency patient transport is provided to meet medical need. It will also signal commitment to the service, helping to improve longer term planning and staff morale and so improve service quality
<i>Work with others to improve the service</i>	
Explore options for improving patient focus, efficiency and effectiveness in partnership with ambulance services, local authorities and others	Identify opportunities to make savings and to provide customers with integrated, patient- and user-focused services
<i>Review funding</i>	
Set realistic budgets that reflect demand and service standards and monitor expenditure regularly and effectively	Take account of service standards when setting budgets and reduce the likelihood of budget overspends
Do so taking account of the impact of non-emergency PTS on 'did not attend' rates and on discharge delays	Set budgets that take account of how non-emergency PTS contributes to the effective use of NHS resources
<i>Plan for change</i>	
Review how non-emergency PTS and its funding need to change in response to the challenges ahead	Ensure that arrangements respond to changes in healthcare and social care and to joint commissioning

cont./

RECOMMENDATIONS



Action by health bodies (continued)

AMBULANCE SERVICE SHOULD:	THIS WILL:
Work with commissioners on the above agenda	Improve patient-focus and the use of resources, raise the status of non-emergency PTS within ambulance services and help with the response to change
Continue to explore opportunities to make better use of resources and to improve value for money without compromising safety or patient-focus	Ensure that public money is used effectively

Source: Audit Commission

Conclusion

142. Home-to-school transport, social services transport and non-emergency patient transport play key roles in allowing many people to access public services. Their users include some of the most vulnerable people in modern society – children and older people and adults and children who are ill or who have physical or other disabilities. Managed effectively, they can also contribute to broader policy objectives, by promoting social inclusion and helping to meet the environmental agenda.

143. There are many examples of good practice, and many good, hard working council and NHS staff, and contractors. However, there are also opportunities for efficiency improvements. Transport services have often been viewed as diverting resources from frontline activities, rather than as ensuring that people reach services and as forming part of a package of education, or social care or healthcare. Managerial attention has focused strongly on finance and cost, sometimes to the detriment of customer care and user- or patient-focus. A reappraisal of emphasis is needed as public services modernise and expectations change. Central government can help by reviewing the framework within which councils and health bodies work. But these bodies can still do much now to build on existing good practice to provide safe, effective, user-focused and more integrated transport arrangements that provide fair access to vital public services.

Local authorities and health bodies visited during the study

Appendix 1

Local authorities:

Carmarthenshire County Council

Derbyshire County Council

Devon County Council

Leeds City Council*

Lewisham Borough Council

Merthyr Tydfil County Borough Council

Nottingham City Council

Staffordshire County Council

Suffolk County Council

Worcestershire County Council

* The project team also visited West Yorkshire Passenger Transport Executive as part of this field-visit

Health bodies:

East Anglian Ambulance Service NHS Trust

Greater Manchester Ambulance Service NHS Trust

London Ambulance Service NHS Trust

North Eastern Ambulance Service NHS Trust

Surrey Ambulance Service NHS Trust

Warwickshire Ambulance Service NHS Trust

Welsh Ambulance Service NHS Trust

Westcountry Ambulance Service NHS Trust

Addenbrooke's NHS Trust

Central Manchester NHS Trust (Manchester Royal Infirmary)

Guy's and St Thomas' Hospital NHS Trust

Hammersmith Hospitals NHS Trust (Charing Cross Hospital and Hammersmith Hospital)

Newcastle General Hospital NHS Trust

Queen Elizabeth NHS Trust (Greenwich)

Royal Devon and Exeter NHS Trust

South Tyneside Healthcare NHS Trust

Tameside Community and Priority Care NHS Trust

University Hospital Birmingham NHS Trust

University Hospital Lewisham NHS Trust

Warwick Hospitals NHS Trust

Focus groups

Appendix 2

In addition to holding informal interviews with service users on vehicles in each fieldwork site, the Audit Commission held a series of focus groups with service users with more specialised needs or with their parents and carers. These were:

On patient transport services

- Renal dialysis patients (held in London; attendance from across England)
- Carers and volunteers working with renal patients (London; attendance from across England)
- People who have visual impairments (city in Midlands; local attendance)

On social services transport

- People who have visual impairments (city in Midlands; local attendance)
- Adults with moderate learning difficulties (city in Midlands; local attendance)
- Adults with severe learning difficulties (city in Midlands; local attendance)
- Adults attending social services day centre, including people with physical disabilities (city in North; local attendance)

On home-to-school transport

- Deaf parents of deaf children (London; attendance from across South East)
- Deaf children (city in Midlands, local attendance)
- Children with moderate learning difficulties (town in North; local attendance)
- Parents of children with moderate and severe learning difficulties (town in North; local attendance)

Attendants at these focus groups included people resident in more rural areas. Some people from across England and Wales also gave views by telephone or in writing. Additional information was gathered from focus groups held by the Audit Commission's best value inspectors when inspecting local authorities' best value reviews of transport arrangements.

Appendix 3

The advisory group

The members of the Group were:

Lindsey Baker, Department for Education and Skills

Martin Camillin, Department for Education and Skills

Alan Carter, Surrey Ambulance Service

Neil Comport, Department for Education and Employment*

Tim Davies, Devon County Council

Sara Ford, Department for Education and Skills*

Ann Frye, Department for Transport, Local Government and the Regions

Glenys Lawrence, Wandsworth Borough Council

Stephen Lowe, Age Concern

Terry McCrady, NEXUS (Tyne and Wear Passenger Transport Executive)

Brian McGinnis, MENCAP

Pamela Marsh, Department of Health

Jenny Meadows, Community Transport Association

Paul Topham, Calderdale Metropolitan Borough Council**

- * Sara Ford succeeded Neil Comport on the Advisory Group part of the way through the study.
- ** Paul Topham joined Calderdale from East Sussex County Council part of the way through the study.

Appendix 4

Policies on home-to-school transport at the Commission's fieldwork authorities

LEA	Primary	Secondary	Post 16	Denominational	Additional provision
1	Statutory distances only.	Statutory distance only.	Free transport is provided but is to cease in 2004; concession will continue for those on school registers prior to the end of the Summer term of 2000.	Transport up to 8 miles from home address on religious grounds.	Assistance may be provided for medical conditions, for those continuing a course to an advanced level in a subject that had previously been followed at the designated secondary school, or for a change of residence in a final exam year. Spare seats sold at 75p per day – waived for those on family credit or income support.
2	Statutory distances only.	Statutory distance only.	Ceased in 1996 but existing arrangements protected; 16-19 year-old students in full time education eligible for half-fare travel passes.	Free transport provided to 'normal area school' (normally the nearest denominational school); in the case of Catholic schools, only baptised children are eligible for free transport.	Not normally provided to meet parental choice except via formal appeal; spare places on contract vehicles are sold on a concessionary fare basis.
3	Statutory distances only.	Statutory distance only.	No free transport unless exceptional educational, medical or social reasons. Subsidised transport requires contribution of £200 p.a. (£100 for students involved in Smartcard pilot). Waived if family is on certain benefits. Normally no subsidy for travel under 3 miles. Subsidised for designated school/nearest establishment offering essential/appropriate course (definitions based on type of course).	None free, if not 'nearest suitable' school. Subsidised transport provided but with a parental contribution of £200 p.a. Fee waived if family in receipt of certain benefits. Policy changed from free travel in 1999. Pupils travelling without charge before then continue to do so.	Not provided to meet parental choice except for exceptional educational, medical or social reasons.

LEA	Primary	Secondary	Post 16	Denominational	Additional provision
4	Statutory distances only.	Statutory distance only.	Bus passes provided for 16-19s if student is attending school/college full time at nearest appropriate establishment for their course of study and it is in the area of validity for the local school card (bus pass).	Free transport for Church of England schools if pupils attend nearest appropriate school and travel over statutory distance, also free for Catholic schools if pupils attend catchment school designated by the diocese and travel over the statutory distance (including to designated schools outside LEA).	Some free transport for pupils moving house if pupil is in final year before transfer or is on a course leading to a major public exam (years 10-13). Also free provision for medical need if requested by medical specialist and parent cannot assist.
5	Statutory distances only.	Statutory distance only.	Sixth form maintenance grant for £400 for young people aged 16-19 who travel over 5 miles and are part of a family receiving benefits; minor awards for 16-19 year olds attending further education.	No specific provision to denominational schools below statutory distances.	Some provision of car mileage for parents driving their children to school (eg, for children with physical difficulties).
6	Free provision from 1½ miles up to age 11, even for schools outside the authority.	Free provision from 2 miles.	All students aged 16-18 at start of September attending full time study entitled if travelling at least 2 miles and attending nearest appropriate college.	Free transport provided if pupils meet LEA distance criteria (ie, as outlined under previous columns).	Authority financially supports 6 non-statutory school services. Paying buses are arranged for pupils within discretionary limit; flat rate charge for children travelling under 2 miles using vacant seats, independent of parental income.
7	Statutory distances; discounted travel pass if child travels 2 miles or under.	Statutory distance discounted travel passes until end of educational year in which 16th birthday falls (end of year 11).	Students in receipt of Educational Maintenance Allowance get free transport. Others may obtain passes; Smartcard scheme provides half fare travel on most local buses, trains and community transport, (available also to under 16s).	Free travel for those attending the designated denominational school who live over statutory distance.	Only a few awards per year on a discretionary basis.

LEA	Primary	Secondary	Post 16	Denominational	Additional provision
8	Statutory distance to age 8, free travel for 8-11 year olds travelling over 2 miles.	Statutory distances only.	Post 16s pay set rates, LEA pays an element.	Free travel where schools have agreed catchment areas with dioceses if over 3 miles; expectation schools will check pupils' faith.	
9	Provision for pupils up to age 11 who live 1½ miles or more from school.	Statutory distance if aged over 13. For pupils aged 11-13, distance of 2½ miles applies. Pupils of 13 and over living marginally below 3 miles also given free transport.	Students must either be attending a course at the catchment area school or an approved full time course at a local FE college. Student must be normally resident and live at least 3 miles from the school/ college; other applications may be considered for vacant seats on hired vehicles. Charges are subsidised; fee is waived for those in receipt of certain benefits or for 3rd child. Standard charge £63.50 per term for 'under distance', £92 for out of catchment area.	Free transport for resident, baptised Roman Catholic pupils living in catchment areas of the schools concerned (subject to statutory distances). Proof of baptism or other confirmation of adherence to the faith may be required.	
10	Statutory distances only.	Statutory distance only.	Students may get a travel pass at half fare rates if eligible for Education Maintenance Allowance - not dependent on distance or location of college/ school. For other students, assistance is provided if they attend full time, are aged 16-19 at start of September, are ordinarily resident, attend the nearest school /college and are attending a appropriate course (conditions apply). Students pay £69 per term, or £12 per term if parents receive benefits.	Recent change – previous pupils protected until they transfer school. Now assistance given where parent or pupil adheres to the religion and application is supported by proof of baptism or by local priest or vicar and pupil lives beyond walking distances and is attending the nearest denominational school. For shorter journeys, some assistance with costs may be provided.	Discretion exceptionally provided, where pupils moving house are taking an exam and need to complete this before changing schools and the new address is beyond statutory walking distance; or where there are no places at the nearest school and the alternative is beyond the walking distance. Vacant seats are sold at rates dependent on family's financial circumstances.

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Other reports of interest, published by the Audit Commission.

The Special School Run
Reviewing Special Educational Needs
Transport in London

There are useful lessons to be learned nationally from this London based study of special educational needs transport. The report focuses on helping authorities to bring about improvement in their home-to-school transport for children who have special educational needs. It includes comparative information on policies, arrangements and costs across London, and a self-assessment checklist that can be used by authorities to review their SEN transport arrangements.

*National Report, 2001, ISBN 1862402787, £20,
stock code LNR 1597*

Charging with Care
How Councils Charge for Home Care

Charging with Care explores the variations in home-care charging. It looks at why these variations have occurred and at the consequences of different charging arrangements for users. This report also examines what councils can do to improve the way they manage their charges and shows how best value reviews provide an opportunity to improve the design and management of charges. Charging with Care will be of interest in the wider debate surrounding the funding of long-term care.

*National Report, 2000, ISBN 1862402221, £20,
stock code HNR1392*

The Price is Right?
Charges for Council Services

This report analyses why councils are not getting the best out of charges and demonstrates how barriers operate to hinder their effective management. It presents a model – the charging cycle – which can be used to overcome these barriers, alongside a series of good-practice case studies. The report also shows how the current, unsatisfactory position can be resolved – at the council level – by using the opportunities provided by best value reviews and value for money audit; and at the national level, by reviewing the current legal framework.

*National Report, 1999, ISBN 1862401519, £20,
stock code LNR1344*

Life in the Fast Lane
Value For Money in Emergency
Ambulance Services

Ambulance trusts offer patients not just a rapid response and swift transport to hospital, but often a valuable first stage to their clinical care. The volume of emergency work has grown at around 5 per cent per year since 1990, placing ambulance services under increasing pressure to meet demanding national targets for response times and combining operational efficiency with effective patient care. Highlighting the benefits of joint working with other service providers and health authorities, this report describes practical examples of how services are tackling these problems. It is essential reading for all involved in managing and improving the delivery of ambulance services.

*National Report, 1998, ISBN 1862400644, £20,
stock code HNR1281*

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Home-to-school transport, social services transport and non-emergency patient transport enable many people to access public services. These services cost about £900 million a year. Their users include some of the most vulnerable and deprived people in society. The complex and fragmented arrangements for supporting travel are likely to confuse some users, while some people are not satisfied with current arrangements. Their concerns include the time taken to go to and from hospital; poor quality vehicles, rude drivers, poor driving and vandalism and bullying on mainstream home-to-school transport; and unprofessional behaviour – such as rudeness; smoking on duty; and swearing – by some drivers on transport to special schools and social services facilities. Service standards also vary significantly. For example, vehicle crews are not always trained, provided with information about passengers' needs or screened by the police when they should be.

This report sets out ideas for improving transport services, in the context of new challenges – such as the joint commissioning of health and social care; increasing inclusion of children with special educational needs in mainstream schools; more patient-focused health services; more individually designed packages for social care and a greater emphasis on after-school activities in education. A reappraisal is needed as public services modernise. Central government should review the framework within which councils and health bodies work. But local authorities and health bodies also need to act. Managed effectively, the transport services they provide allow people to access public services, thus promoting social inclusion. They also help to meet the environmental agenda, by reducing the use of cars.

For those seeking more detailed guidance on social services transport, mainstream or special educational needs home-to-school transport and non-emergency patient transport services, a series of four handbooks is also being published by the Audit Commission in December 2001. These offer examples of good practice and self-assessment checklists for service managers.

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