Improving Non-Emergency Patient Transport Services
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For more information on the work of the Commission, please contact:

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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 allow people to access education, social services and health services. A national report, *Going Places: Taking People to and from Education, Social Services and Healthcare*, which the Commission recently published, summarises the Commission’s overall findings and contains recommendations for action by central government and by senior managers in local government and the health service.

This handbook, *Improving Non-emergency Patient Transport Services*, contains detailed examples of good practice together with self-assessment checklists. It can be used by those in the health service who deal with policy on, and eligibility for, non-emergency patient transport services and those who are arranging, managing and providing the transport.

This handbook is based on: findings from field visits to eight ambulance services and to 12 commissioning trusts; focus groups with patients and carers; discussions with ambulance service staff, staff at hospital trusts, including some clinicians, volunteer drivers and patients during fieldwork visits; work by the Commission’s auditors with individual ambulance services and hospital trusts; and analyses of national data and of information provided by the Ambulance Services Association.

Further details of the research are given in *Going Places*. Alongside this guidance, the Commission is issuing similar material on three of the other areas examined in its study, *Improving Mainstream Home-to-School Transport*; *Improving Home-to-School Transport for Children with Special Educational Needs*; and *Improving Transport for Social Services Users*.

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

Introduction

Non-emergency patient transport services (PTS) allow people to access outpatient and other services at NHS hospitals. A range of people use them, including the young and elderly, some of whom may have physical or other disabilities, and may be seriously ill or injured. Many of the users are vulnerable and depend on the free transport that they receive.

Poor access to health services because of a lack of, or infrequent, public transport, or high transport costs, is a major factor in social exclusion and rural isolation. Free non-emergency PTS helps to overcome this problem. It also brings other benefits. It may help to increase attendance rates at outpatients’ clinics (by patients who might find it difficult to, or forget to, attend if the transport had not called at their homes). This, in turn, can reduce hospital non-attendance levels and improve the effectiveness of treatments and the efficiency with which the NHS uses resources. As transport may be required when patients are discharged from hospital, non-emergency PTS also helps to ensure that people leave hospital as soon as they are fit to do so, reducing bed blocking.

Although some hospital trusts provide non-emergency PTS in-house or use private sector providers, ambulance service trusts in England still provide or arrange the great majority of non-emergency patient journeys. English ambulance services:

- provide about 14 million non-emergency patient journeys a year, over 80 per cent of all patient journeys made using ambulance services [EXHIBIT 1] – this equates to taking on average nearly 30,000\(^I\) people to and from hospital each working day; and
- spend about £150 million a year on non-emergency PTS. Expenditure on non-emergency PTS changed little, in real terms, over the 1990s as total ambulance service costs rose. Non-emergency PTS now accounts for about 20 per cent of ambulance service expenditure compared with about 25 per cent early in the 1990s [EXHIBIT 2]. In a typical ambulance service, a (one-way) patient journey costs on average about £9.

In 1999/2000, the Welsh Ambulance Service provided 1.3 million patient journeys, equivalent to taking over 2,500 people to and from hospital each working day\(^II\). This rose to nearly 1.4 million in 2000/01.

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\(^I\) The number of journeys per day is based on the assumption that, on the whole non-emergency PTS is a Monday to Friday service. As this work is typically delivered on weekdays, 251 working days has been used as the denominator.

\(^II\) The number is again based on a 251 working day year.
EXHIBIT 1

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 ambulance service costs.

Source: Audit Commission analysis of Department of Health data.

EXHIBIT 2

The number of non-emergency PTS journeys provided by English ambulance services

There are about 14 million non-emergency PTS journeys a year.

Source: Audit Commission analysis of Department of Health data. Non-emergency PTS journeys taken as equivalent to ‘special/planned’ journeys. Data is for England only. All ‘patient journeys’ is the sum total of ‘emergency’, ‘urgent’ and ‘special/planned’ journeys.
This handbook sets out good practice for health service commissioners and providers of non-emergency PTS to assist them in reviewing and improving the service they deliver. This seeks to address some of the concerns of stakeholders [BOX A]. The good practice lessons emerging from the Commission’s research are drawn together under three themes:

- **The policy context for non-emergency PTS**
  This section considers the wider policy context within which non-emergency PTS operates. As well as discussing the obligations of health bodies, it also discusses the role of non-emergency PTS in providing access to health services, reflecting the patient focus set out in *The NHS Plan* I and *Improving Health in Wales* II.

- **Commissioning non-emergency PTS**
  This section discusses the role of service commissioners who let and oversee non-emergency PTS agreements. It discusses eligibility for non-emergency PTS and patient safety, service quality and commissioning issues.

- **Providing non-emergency PTS**
  This section covers aspects of non-emergency PTS from the provider perspective. It considers resourcing, safety, service quality and costing and charging. It also covers options for linking the provision of non-emergency PTS with other transport such as social services or special educational needs home-to-school transport.

Some issues are discussed in both sections two and three as they apply to both commissioners and providers. Each section ends with a checklist to help health bodies assess how their own arrangements compare with good practice.

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BOX A
What do stakeholders think about the service?

Patients

‘Some days I spend all day on transport. I don’t drive because of my eyesight – I have given up my licence... There was one time I was supposed to go to the renal unit and they came two and a half hours early. The driver started trying to drive off because I wasn’t ready. I got in and asked ‘where are we going?’ and ended up in the city hospital. I had cancelled an appointment there for chiropody because of a clash of appointments and they hadn’t cancelled the transport. They brought me back and I had to get another transport [to the renal clinic where I was meant to be going] so I was three hours late! I got there just before lunch and managed to be finished by lunch to see the renal consultant.’

Renal patient

‘The problem is with ambulances – they may not specify electric chairs and if there is more than one electric chair they’re not allowed to take it on an ambulance for health and safety reasons. I paid for a taxi and was not offered reimbursement – then was told if you got yourself in this morning, you can get it yourself again. It costs £13-£14 for a round trip to the infirmary!’

Wheelchair patient

Ambulance staff

One driver interviewed on fieldwork explained,

‘The best thing about the job is the people; they’re usually good as gold. Some of them have seen two world wars, and would not mind waiting.’

He was interested in working in A&E ambulances but had decided to try non-emergency PTS first. He was concerned by the poor quality of the vehicles and also disliked the area’s traffic congestion but noted that, often, other drivers were more considerate when they saw an ambulance. A recurrent problem he faced was finding people no longer wanted patient transport when he arrived to pick them up. In his view, the drivers were ‘the last to know’.

In two cases he had called to pickup a patient who had died – while the relatives were very good about it, he found this awkward and embarrassing.

Non-emergency PTS ambulance driver

Volunteer car drivers

‘Initially when I started I could see a lot of shortcomings. To my knowledge [the] service has been running for 30 odd years... nothing was being done... we calculated how many [journeys] are aborts. [We estimated that] £1,180,000 is wasted in [our] ambulance service... No one in my management system has an interest in me and it’s because I’m a volunteer.’

Volunteer car driver

Clinical staff in hospitals

‘There is a culture that transport is offered fairly freely, especially in clinics, and medical staff will sign anything – there has been work on this though. Ward sisters are encouraged now to question everyone about their transport needs pre-discharge. They tell people it’s better if they can go home under their own steam and some do get taxis to avoid waiting.’

Doctor working in elderly services
‘Renal patients hate their transport more than their treatment...’

Senior renal nurse

“We now use the all-day clinic for transport patients. We wouldn’t book people in on [one] morning because people turn up late. [The department] has a contracted doctor from 9.00-1.00 pm and if the patients have not turned up they will not see anyone – patients would then need a new appointment... If it’s booked in at 9.30 it can come in at 12.45 – sometimes I worked out I could have walked a patient here quicker.’

’Surgeons have to be careful how to do their lists- normally they do small operations first but if one is a transport patient there’s no guarantee they’ll be in, so they may have to re-jig the list. If a transport patient is not in to be assessed on time you may have to bleep the anaesthetist to come out to see patients between operations. These problems mean we almost automatically try and get the patient in the night before, so it affects how you run the service and your efficiency. Some consultants only operate once a week. The problem with transport is if they don’t do weekends, you’d have to bring people in on Friday for Monday morning – meaning casualty then can’t use the bed.’

‘There used to be a list of what £25 could buy and if people repeatedly did not attend a letter went out to them showing them. They don’t realise they’re stopping other people. [The hospital] has a sign showing the DNA rate and number of failed appointments. We try and call and remind people of appointments. With the new direct booking system – if we cannot offer an appointment in six weeks we send a holding letter to say so and tell people you should have one in the next six weeks. This should eliminate part of the problem – if people wait 3 months they’re more likely to forget [their appointment].’

Nurses in a surgery department

Hospital PTS managers

‘Devolving budgets has led to managing demand. But where additional investment is made in the NHS, this has a direct implication for [non-emergency] PTS – so trying to control it is difficult.’

Hospital PTS finance officer

‘This hospital is not a district general hospital drawing only from its own locality – if so, we could use a small ambulance service or run it ourselves. We use 19 vehicles – I don’t know any private ambulance services that could provide this.’

‘When I got involved I wanted a service until midnight from [the ambulance service]. I tried to make our contract patient-focused and include quality issues – I wanted to offer a token gesture for problems like a bunch of flowers to people – [the ambulance trust] said no, it was unheard of.’

‘[The ambulance service] is coping with up to 10 per cent over the [patient journey] limit then turning people down... Quality is directly affected by quantity... Complaints were decreasing but now they’re increasing again... the volume issue means we are saying no inappropriately.’

Hospital non-emergency PTS managers

‘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 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: Audit Commission
1. The policy context for non-emergency PTS

1. Non-emergency PTS operates in a context in which:
   - people need to have simple access to health services; the best health services are of little use if patients cannot get to them;
   - eligibility for free non-emergency PTS is based on a ‘medical need’ criterion issued ten years ago, which is interpreted in many different ways;
   - the Hospital Travel Costs Scheme is available to meet some peoples’ travel costs when they attend hospital; and
   - the service has links to the Government’s wider policy objectives, such as addressing social exclusion and reducing car dependency.

Access to health services

2. Public services are becoming increasingly customer and user focused as they modernise. Fair access to patient-focused services is a central theme in both *The NHS Plan* and in *Improving Health in Wales* (the NHS Plan in Wales); and better transport and better access feature strongly in the public’s concerns about the NHS [BOX B]. Patients’ expectations about both the availability and the quality of the transport needed to allow them to access health services are likely to rise.

3. Accessibility is enhanced by:
   - the presence of affordable and available transport services to and from hospitals;
   - clear guidelines on eligibility for these services; and
   - clear information for patients on these services.

4. Some hospital trusts provide information to patients on how to get to hospital when appointments are made or confirmed in writing. In Devon, the Royal Devon and Exeter NHS Trust and Westcountry Ambulance Service together with the county council, community transport bodies and other partners, have produced a leaflet outlining the range of options available to patients. Elsewhere in Devon, the TRIP initiative offers a single point of contact about travel options [CASE STUDY 1].
BOX B

Increasing user and patient focus

The NHS Plan states:

‘The NHS will provide access to a comprehensive range of services …

‘The NHS will shape its services around the needs and preferences of individual patients, their families and their carers …

‘Patients and citizens will have a greater say in the NHS, and the provision of services will be centred on patients’ needs …

‘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. The NHS will develop partnerships and co-operation … to ensure a patient-centred service.

‘This is a Plan for investment in the NHS with sustained increases in funding. This is a Plan for reform with far reaching changes across the NHS. The purpose and vision of this NHS Plan is to give the people of Britain a health service fit for the 21st century: a health service designed around the patient.

‘Patients should have fair access and high standards of care wherever they live.

‘Members of the public said that they wanted to see better transport and access to services …’

* * *

Improving Health in Wales: A Plan for the NHS and its Partners 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
**CASE STUDY 1**

**Improving information on getting to hospital: Devon**

In Devon, the Royal Devon and Exeter Hospital NHS Trust, Westcountry Ambulance Service, the Community Health Service, Mid Devon PCG, the North & East Devon Health Authority, the County Council and local community transport groups co-operated to produce the leaflet *How Do I Get to Hospital from the Mid-Devon Area?* This includes a flowchart showing when people may be eligible for the Ambulance Car Service and also gives details of local bus services and contact numbers for community car schemes and wheelchair accessible taxi services.

*     *     *

Elsewhere in Devon, the Honiton-based TRIP community transport association co-ordinates a range of transport arrangements. TRIP:

- books the Ambulance Car Service on behalf of the local health centre;
- can also book people into two other voluntary car schemes, to take patients to and from the Honiton centre and another local GP practice;
- takes booking for the Honiton Ring and Ride service;
- takes bookings for local flexibus services (that is, bus services that have fixed start and finish points and times but that take bookings and will call at people’s homes in rural areas between those fixed points); and
- takes bookings for a Fare Car scheme.

TRIP acts as a single point of contact for travel arrangements for people with mobility problems or whose homes are not well-served by public transport. If people are not eligible for the Ambulance Car Service, it can provide advice on alternative ways of travelling and, in many instances, arrange the transport.

Source: Audit Commission

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**Eligibility for non-emergency PTS**

4. Under NHS guidance issued in 1991, non-emergency PTS to and from hospital is provided free of charge when patients have a medical need; they can be charged when the transport is provided for social reasons. Non-emergency PTS does not cover travel to general practitioners (GPs), dentists or opticians. Nowhere, however, does the 1991 guidance explicitly state what medical need is: there is no simple ‘medical need’ criterion for those who order transport.
The Hospital Travel Costs Scheme

6. The Department of Health’s NHS Hospital Travel Costs Scheme seeks to address affordability barriers to travel to hospital for people who are not entitled to free non-emergency PTS [BOX D]. 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\(^I\). This is approximately 10 per cent of the annual expenditure on non-emergency PTS.

7. The National Association of Citizens Advice Bureaux (NACAB) has recently reported upon the cost of travel to health services, in its report *Unhealthy Charges*\(^II\). Evidence to it from local citizens advice bureaux indicates that people entitled to help under the Hospital Travel Costs Scheme often do not receive it because:

- there is 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 low knowledge about the scheme by health professionals, resulting in misinformation to patients.

\(^I\) Information provided to the Audit Commission by the Department of Health. Provider units are responsible for administering the scheme and making payments to patients. Health authorities are responsible for reimbursing provider units to all patients who are resident in their districts. GP practices are not funded for the HTCS and should reclaim the cost of any payments for directly referred patients from the relevant health authority.

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 clinic. The evidence from local citizens advice bureaux suggests that bureaux clients in rural areas are particularly affected by inadequacies in help with travel costs.

The wider policy context

‘The journey [to hospital] is a strain, it takes about 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].’


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1 Department of Health, Chapter 28, The Hospital Travel Costs Scheme of The NHS Finance Manual, Department of Health, 2000 and information on the Department of Health website, see www.doh.gov.uk/hospitaltravelcosts/reimbursement
9. The Government is giving a high priority to addressing social exclusion and rural isolation. In addition, its wider transport policy recognises the need to address car use because of the environmental impact of traffic congestion and air pollution.

**Social exclusion**

10. Inability to access health services is one example of social exclusion. Some people cannot afford private transport. People who use wheelchairs need to travel in vehicles that can carry their chairs; these tend to be larger and costlier than the average private car, increasing affordability barriers. Alternatively, people may not use private transport because no one in the household knows how to drive. Illness or disability may prevent younger people from learning to drive; many older people may never have learnt to do so. While increasing proportions of elderly people have driving licences, many still do not, particularly women. Elderly women, most of whom live alone, are therefore less likely than elderly men to have access to a car [EXHIBIT 3]. Other people may no longer be able to drive.

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**EXHIBIT 3**

**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.

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11. Some people without access to a car are not easily able to use public transport. In some parts of the country, especially in parts of the North East, Lincolnshire, parts of Yorkshire and the West Midlands, over 10 per cent of households live more than 12 kilometres from a hospital. Even where there are adequate services, restricted mobility and other medical conditions – such as failing hearing or sight, breathing difficulties or communication difficulties – may make it difficult to use public transport. High steps getting on and off buses and trains, and steps at railway stations, present serious barriers to access for many people. Being too frail, and becoming easily tired travelling to a bus stop, as well as concerns about safety because of the poor condition of pavements or inadequate road crossing facilities and poor access to information, are all further barriers. The cost of travel by taxis or minicabs can be a barrier to their regular use. In addition to the Hospital Travel Costs Scheme, a number of other schemes try to address these accessibility and financial barriers to travel [BOX E].

BOX E

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 one that offers at least a half-fare bus concession but they can have schemes that offer 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.

- Dial-a-ride and ring and ride schemes. These are specialist minibus services that offer door-to-door travel for people with 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.

- Taxicard: Schemes, such as those funded by London boroughs, which 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 costs for the journey. Drivers need to comply with all 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

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12. Much of the support available to people varies according to where they live – voluntary schemes such as dial-a-ride do not yet cover the entire country; Taxicard schemes are comparatively rare outside London; and concessionary fares schemes differ from place to place. In many parts of the country, and particularly in the more rural areas, community transport organisations play an important role in taking people to medical services [CASE STUDY 2].

13. Even where there is a significant level of transport provision, people may still have to deal with a number of organisations to make arrangements to use them. 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 he or she might use 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 hired-car. If the patient is receiving benefits, in order to recover the cost through the Hospital Travel Costs Scheme he or she would first need to be aware of the scheme and then go through the bureaucracy of claiming. This is likely to be a particular problem for elderly or frail people, those with learning or literacy difficulties, or those whose first language is not English. For many people, applying for help is complex and may be a significant barrier to obtaining support.

CASE STUDY 2

Links with other transport services: East Anglia

In the area covered by the East Anglian Ambulance Service – one of the most rural in England and Wales – there are important transport contributions from community organisations. In some parts of the Service’s area – for instance, Cambridgeshire – these efforts are co-ordinated and planned with inputs from a voluntary organisation and a Primary Care Group. Tesco also fund and operate a free bus service from the Fulbourne area of Cambridge to Addenbrookes.

While community transport services are widely available throughout East Anglia, there are sometimes restrictions over who can use them; for example a bequest from one person has funded an ‘independent’ hospital car service in one parish of Norfolk – which is not available for patients living outside that parish.

The East Anglian Ambulance Service recognises the collective contribution that all such services make to getting people to health facilities in East Anglia. It hopes, in the longer term, to establish itself in a co-ordinating role – helping to make sure that each voluntary service contributes efficiently to solving the region’s hospital transport difficulties.

Source: Audit Commission
14. Elderly and unwell people are not likely to find the 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.*

15. In London, 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 for people who are judged not to be in medical need of non-emergency PTS but do not have access to a car and have mobility difficulties – apart from, possibly expensive, taxis or hire-cars.

The environmental agenda

16. Some hospitals have policies to increase the proportion of patients, visitors and staff travelling to hospital by means other than private car. In some instances this has involved measures to control and manage car parking within hospital sites. In others, measures have addressed improving access for public and other transport services [*CASE STUDY 3*].

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**CASE STUDY 3**

Improving access to hospitals: South Tyneside Healthcare NHS Trust

The South Tyneside Healthcare NHS Trust invited in a car park contractor (ACPOA) to clear the site and establish a paid car park – charging 60p for 3 hours. The new car park eased the access to the site so that a bus (that originally could not travel the 300 or so metres from the road to the main outpatient department because of badly parked cars) can now get to the hospital door.

*Source: Audit Commission*

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17. If health bodies are to respond to wider problems, they need to work with others to take a holistic view of how people are to reach services. The need for, and role of, non-emergency PTS should be included in this. Hospital trusts can work in partnership with local authorities and public transport operators to identify how to promote social inclusion and tackle environmental concerns, and be involved when local authorities prepare their statutory annual Local Transport Plans. Hospitals should also be developing their own travel plans, which could address access issues for patients needing non-emergency PTS. At present, some patients face great difficulty or hardship in travelling to and from health services.

18. Health bodies can use the following checklist to identify any gaps and priorities for action, and to inform policy development.
## Self-assessment checklist for commissioners

**Access to health services**

Does the commissioning body properly co-ordinate transport services? For example, is a single person responsible for making the links between car park charging and ambulance demand, and the links between ambulance and public transport services?  

Has the commissioning body considered how *The NHS Plan or Improving Health in Wales* (the NHS Plan in Wales) will affect transport?  

Does it have an overall policy towards access to and travel to health services (including access to GPs, dentists etc)?  

Does it have a hospital travel plan to support this policy?  

Does it have separate travel policies for:  

- patients?  
- visitors?  
- staff?  

Does the commissioning body consider the transport and access needs of patients when organising appointments, and, where practical, consider aligning the two (for instance, enabling elderly people with bus passes to come at a time when they can use these passes where this is realistic)?  

Does it have a reliable estimate of how patients get to their hospital appointments (numbers and proportions using car, public transport, ambulance, and walking)?  

Does it produce and distribute any leaflets (targeted at patients) which explain how to get to hospital?  

**Eligibility for non-emergency PTS**

Does the commissioning body have any policy statements about the use of non-emergency PTS?  

Has it examined whether the provision of free transport increases the likelihood of a patient attending an appointment?  

**The Hospital Travel Costs Scheme**

Is the commissioning body using the Hospital Travel Costs Scheme to assist patients on low incomes to travel to and from treatment?  

Does it know how many patients use the Scheme each year and what it costs locally?  

**The wider policy context**

**Social exclusion**

Has the commissioning body examined whether elderly patients have special problems with transport to clinics and medical services?  

Has it examined whether patients in rural areas have special problems with transport to clinics and medical services?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Has it examined whether other client groups (for example, urban poor, drug users, people with mental health problems or asylum seekers) have special problems reaching appointments?</td>
<td>☐</td>
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<tr>
<td>Has it taken any steps to address any such problems?</td>
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**The environmental agenda**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Has the commissioning body considered the potential to reduce car use for travel to and from hospital?</td>
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<tr>
<td>Has it influenced, and been consulted by local authorities on their Local Transport Plans?</td>
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<tr>
<td>Has it held any discussions with local bus or other public transport operators about the provision of transport to hospital?</td>
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<tr>
<td>Are wider links with the voluntary sector reflected in local transport arrangements?</td>
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</tr>
<tr>
<td>Do any dial-a-ride schemes deliver direct to hospital?</td>
<td>☐</td>
</tr>
<tr>
<td>If not, has the commissioning body encouraged them to do so?</td>
<td>☐</td>
</tr>
<tr>
<td>Has it deliberately tried to influence how patients and visitors travel to hospital (for example, to decrease car use, and increase bus use)?</td>
<td>☐</td>
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<tr>
<td>Has it engineered any shifts in modal use (for example, reducing car use by increasing car park charges)?</td>
<td>☐</td>
</tr>
<tr>
<td>Are hospital car parking charges part of a wider transport and travel policy that take account of how patients are to reach hospital?</td>
<td>☐</td>
</tr>
<tr>
<td>If car parking has been restricted, or if charges have been increased, has the hospital analysed demand for non-emergency PTS to see if the changes have led to an increase in its use?</td>
<td>☐</td>
</tr>
<tr>
<td>Does the hospital know whether the additional revenue from car parking charges was ‘lost’ to higher non-emergency transport bills?</td>
<td>☐</td>
</tr>
<tr>
<td>Has it considered any approaches – other than raising car park charges – aimed at reducing private car use?</td>
<td>☐</td>
</tr>
<tr>
<td>Has it considered asking for outside help to review the options (for example external consultants)?</td>
<td>☐</td>
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</tbody>
</table>
2. Commissioning non-emergency PTS

‘PTS should be seen as part of an integrated programme of care.’

_Ambulance and Other Patient Transport Services: Operation, Use and Performance Standards, HSG (91)29_¹

19. Commissioners shape non-emergency PTS services. This section considers their role. It discusses:

- **the views of users and other stakeholders**, which are central to any attempt by commissioners to assess and improve services – this section looks at the experiences of both patients and hospital clinicians;

- **commissioning practices**, including the underlying principles for service delivery; eligibility; financial support for access; safety; quality standards; patient care and liaison; and the effective use of resources; and

- **changes in the commissioning framework**, with, for example, the development of primary care trusts (PCTs) in England, and their future role in commissioning non-emergency PTS.

### Stakeholder views

#### The patient perspective

20. Focus groups suggest that patients have mixed views about non-emergency PTS. Some are grateful for the service and praise the staff that provide it. Patients are, for example, generally positive about the attitudes and behaviour of ambulance crews [BOX F]. Some carers do, however, point out that dependency on the service may mean that people are reluctant to express dissatisfaction, and that, in the words of one volunteer working with renal patients, ‘they’re terrified of rocking the boat and therefore jeopardising what they’ve got’.

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**BOX F**

**Patients’ praise for PTS**

‘[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].’

‘I have no complaints about transport.’

‘I am grateful …I don’t know [what I would do without them].’

_Patients_

‘[Ambulance staff and volunteer drivers] across the board are dedicated to the task.’

_Renal carer_

_Source: Audit Commission focus groups_

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¹ _Ambulance and Other Patient Transport Services: Operation, Use and Performance Standards, HSG (91)29, NHS Executive, December 1991._
21. However, a number of patients are dissatisfied. Research by organisations such as Age Concern, and the Commission’s own focus groups, suggest that some non-emergency PTS remains insufficiently patient focused and does not give enough attention to service quality. While there have been occasional criticisms of the quality of care during journeys by volunteer car services\(^1\) [BOX G] and taxi firms, most adverse comments have centred on the time taken to get to and from hospital (and the resulting length of the day at hospital), a lack of information about how long people will have to wait for transport, and on the waiting conditions at hospital [BOX H].

22. 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 day’s pick-ups contain a mix of long established clinic appointments, known well in advance, and others made at short notice. This leaves insufficient time in which to notify patients of realistic pick-up times;
- *consequently 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 an hour later). Offering the same pick-up time to everyone means that many people wrongly believe that their transport is late. Some patients 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. Delays in treatment due to late arrival also impacts on return journey arrangements.

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### BOX G

**A patient’s views on the volunteer car service**

‘We are unable to take my wheelchair to London, as my husband is unable to manage this and help me too on the journey. I therefore have to walk from [the railway station] to [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.’

*Source: Letter from a renal patient to the Audit Commission*

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\(^1\) Sometimes referred to as the Ambulance Car Service (ACS) or Hospital Car Service (HCS).
23. Journey times depend most on the distance to be travelled and local traffic conditions but are also strongly influenced by the number of other patients to be picked up by a vehicle, where they live and how long it takes for passengers to get on or off the vehicle. Arrangements designed to improve provider efficiency (such as those that use larger vehicles to reduce the staff to patient ratio in a service or that maximise the percentage of seats occupied) inevitably increase journey times.

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**BOX H**

Patients’ views on non-emergency PTS

‘They always say to you “be ready at 8.30” they came for me at 10.00. I had an hour and a half to wait…’

‘Everyone has praised them but I’m afraid. No! [shaking head] I think they take advantage of us, blackmail us, because we are blind. [We’re told to] “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”]. I think they take advantage of people. I had an appointment at 1.00 pm…at 8.30 pm [I was still there waiting to go home] and I was starving…and I’m a diabetic. [Producing water bottle and food from bag] ‘I carry things around with me. I always have these with me. Even here. I have to go upstairs [to hospital café]. If you are blind you haven’t a chance.’

‘My biggest criticism is [the] time delay. I have to be ready for 7.00 am but they probably don’t arrive until 9.30 am…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…’

‘When it was essential I had to be at hospital [for radiography treatment] I thought, all this for five minutes in theatre, [you’re] under the gun for three and one-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.’

‘At 3.45 pm I was ready and 7.45 pm I got picked up. I was told there had been a change of shifts from afternoon to evening shifts on the ambulances.’

‘You may have a 9.30 am appointment and have two or three hours to wait till you go back. I don’t think they’ve got enough outpatients’ ambulances – it has to go and pick others up.’

‘If your hospital appointment is early the only problem is waiting to go home. You can wait from 1.00–4.00 pm for an ambulance.’

Source: Audit Commission focus groups
The hospital perspective

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

- poor non-emergency PTS organisation 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; and
- a lack of transport can lead to delays in patient discharge, resulting in bed blocking in hospitals.

25. Some clinical staff have told the Audit Commission of repeated problems with late arrival of transport that is compromising patients’ treatment \[BOX I\]. In some cases, hospital staff have changed their approach to booking non-emergency PTS to try to overcome problems. In one surgery department, staff now prefer to bring patients using non-emergency PTS to the hospital on the night before an operation in case they fail to arrive on time for their pre-operative anaesthetic on the day. In other cases, they request transport earlier than required for scheduled appointments to allow for ‘anticipated’ delays in patient arrivals.

26. Such ‘false’ booking times may add to the difficulties non-emergency PTS managers face in delivering services to meet all the needs of the various hospital departments. They risk creating a vicious circle in which providers of non-emergency PTS increasingly treat target arrival times as unimportant. This practice, and block booking of appointments, will be less possible under the individual appointment times, and telephone and internet booking of appointments by patients or GPs direct, envisaged in *The NHS Plan*.

27. Difficulties with transport can also impact on bed management. A survey of NHS acute trusts by the National Audit Office (NAO) in 1999 found that 24 per cent of trusts identified the availability of patient transport services as a prime cause of delayed discharge\[I\]. In some cases, hospital departments need to give notice of a day or more to non-emergency PTS managers to obtain transport; missing a 1.30pm or 3.00pm deadline for a ‘next day ambulance’ order can easily 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\[II\] can also lead to bed blocking [BOX J].

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\[II\] It is common for occupational therapists, or other hospital staff, and social services to make home visits with patients prior to discharge, to check that they will be able to manage to live independently.


**BOX I**

**Importance of timely transport for hospital staff**

‘The elderly clinic is on the same day as the anti-coagulation clinic and renal clinics, which get priority for transport. 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. There may be issues if the patient has forgotten the appointment, but another DNA reason is the patient is not ready. This may be because they have an 11.00 am appointment and transport arrives at 8.00 am. If their carer has not come they cannot always get ready for 8.00 am.’

Hospital doctor with elderly services

‘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

‘Blood transfusions [and] chemotherapy are dependent on getting a patient in at set times. There could be a knock-on effect if people are in for half-day procedures and are late. If people are in for 3- or 5-day blocks – if they don’t arrive on day one on time they can’t complete their treatment for the week – particularly for oncology. If people come late, staff may stay late if needed for the treatment slot [to be completed]. We might have six slots of 5-day treatments for people every three weeks and these should be regularly spaced. If there is a problem it may delay this for a week or we would hope to keep the patient in as an inpatient on Friday night for Saturday because we don’t have daycare treatment for them at weekends.’

Oncology doctor

‘One outpatients clinic books transport for all to come in at 9.00 am – if you put 9.00 am down hopefully you’ll get people in at a reasonable hour. If patients get a 9.00 am appointment they get worried if they’re late – we tell them it’s ok and we’ll still see them later.

[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.’

Nurses in surgery department

Source: Audit Commission based on interviews with hospital staff
Commissioning practices

‘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

28. Within hospital trusts, non-emergency PTS is often commissioned by staff responsible for ancillary services – such as property management and laundry. This reflects the low priority and low status of the service; it is often wrongly viewed as a non-clinical service that can be ‘purchased’ rather than ‘commissioned’. The reality and significance of non-emergency PTS as an integral part of hospital work needs to be better understood, and clinicians need to be more involved in its specification and commissioning. NHS guidance says that PTS should be seen as part of an integrated programme of care.1 Under this approach, a hospital episode begins when the patient is collected from home and ends when the patient is delivered back home; non-emergency PTS is a fundamental part of the overall experience of going to hospital.

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1 HSG(91)29.
29. Though non-emergency PTS is typically provided by ambulance service trusts, a minority of hospital trusts – such as Guy’s and St Thomas’ Hospital NHS Trust – use an in-house supplier, or contractors. More rarely, as at University Hospital Lewisham, a local authority provides part of the service. Some hospital trusts, and ambulance services, also pass work to taxi or minicab operators. Some of these private operators deliver through direct contracts with hospital trusts; others are involved through sub-contracting by ambulance services.

30. Commissioners’ requirements for the PTS service are set out in service specifications. However, these do not always reflect the needs of individual clinics and departments, which sometimes do not input to the specifications. Moreover, those ordering transport often have little or no idea of what is contained within service agreements. Specifications are commonly rolled forward from year to year without any review (other than perhaps indicative volumesII), even though patterns of outpatient and other care may have altered. The result is that commissioners continue to specify less than perfect services, and operational staff continue to use services that they know are not best suited to the task.

31. There are also tensions, on the one hand, between the changes needed to improve service quality and patient focus, and, on the other, financial pressures to increase efficiency. Too often transport tends to be seen as a secondary activity that diverts resources from frontline patient care, rather than as part of the care package. As a result, budgeting tends to be top down, not bottom up, which creates a finance-driven, not patient-driven, service. Sometimes commissioners largely ignore quality in their efforts to minimise the price of non-emergency PTS.

32. Whoever delivers the service, there are a number of central issues for the commissioner to consider and resolve, including:

- *the principles of service delivery* – why do we need a transport service?
- *local interpretations of eligibility* – who is to receive that service?
- *financial support for access* – how is the Hospital Travel Costs Scheme being used to ensure fair access to transport?
- *safety* – are there adequate measures to ensure the health and safety of patients on all non-emergency PTS vehicles?
- *standards for punctuality* – what quality of service do we want for patients and how is this reflected in our service agreements?
- *patient care and liaison* – are the needs and concerns of patients sufficiently well addressed? and
- *effective use of resources* – are our resources successfully delivering our aims and providing value for money?

These issues are now considered further.

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I Guy’s and St Thomas’ Hospital has an in-house ambulance service plus contracted car service provision with taxi firms.

II Indicative volumes refer to estimated or predicted levels of activity specified in service agreement.
The principles of service delivery

33. Each commissioner should make time to understand how his or her particular hospital service would cope without a transport service, and to consider whether clinical services would be improved by devoting more resources to it. Commissioners should also be aware of changing transport needs.

34. In the past, many hospital developments and changes have taken place with little thought for transport implications. Facilities have been built with no reference to, or budget for, transport; new consultants have been employed, and new services introduced, without considering the impact on transport demand; and sometimes building works are undertaken without considering vehicle accessibility, or the need for transport offices and patient lounges. A new Private Finance Initiative (PFI) hospital in Norwich illustrates the alternative approach. Here the PFI provider sees non-emergency PTS as part of the clinical service, with an intrinsic impact on the delivery of healthcare within the Norfolk and Norwich Hospital NHS Trust.

35. The planned increase in specialisation by hospital trusts, and increased delivery of some health services at local health centres and GP practices, envisaged in The NHS Plan and Improving Health in Wales, will also impact on travel and transport requirements. Hospitals are increasingly running clinics in the evenings and at weekends. Commissioners should ensure that the transport implications of such service developments are properly considered and reviewed regularly as care patterns evolve. This should include identifying and understanding the transport cost implications of new services.

Local interpretations of eligibility

36. Under NHS guidance, the service to and from hospital is provided free of charge when patients have a medical need; they can be charged when the transport is provided for social reasons [Box B, see earlier]. Medical need can be interpreted in different ways. The guidance states that eligibility should normally be decided by individual GPs when referring a patient to the hospital, or by consultants within hospital trusts. However, many involved with non-emergency PTS in both ambulance services and on the administrative sides of hospital trusts are concerned that:

- some free transport is sometimes 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 is being abused by some users, who have reasonable disposal 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
- in practice, most GPs delegate the decision to their receptionists, and many hospital clinicians delegate it to nurses or other staff.

1 As well as, on occasion, by dentists and midwives.
37. The position was very similar in 1990 when the NAO 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 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 the Welsh Office had pointed out that ambulance staff 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.

38. The current guidance on eligibility has done little to clarify the position; ambulance services still have views about social provision and abuse that can be countered by a similar argument to the one offered in 1990. The current guidance refers to the need ‘not to worsen’ a patient’s medical condition when he or she travels. The guidance also mentions that patients should be able to reach hospital in reasonable time and in reasonable comfort, without detriment to their medical condition. Some may argue that this requires a clinical understanding of the impact on the patient’s condition of the worry and stress that may be caused by travel by means other than non-emergency PTS. The guidance also states that the availability of private or public transport and distance to be travelled must be considered. This, therefore, introduces what some might see as a ‘social’ element into the ‘medical’ criterion.

39. Attempts to manage demand (that is, to control the number of people using non-emergency PTS), are made in most health economies. The confusion and uncertainty about eligibility means that this ‘demand management’ is approached differently across the country, with the result that people with similar conditions and similar circumstances are treated 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, who are reminded from time to time of the guidance on eligibility and about the cost of non-emergency PTS. Elsewhere, individual clinics have prepared local criteria for their own use, and, in some instances, ambulance services and hospital trusts have consulted formally with stakeholders about how to interpret the guidance. 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 [CASE STUDY 4].


In Surrey, and in other areas, free provision for ‘walkers’ is being targeted, an approach that especially impacts on volunteer car services. ‘Walkers’ account for over half of non-emergency PTS journeys for most ambulance services [EXHIBIT 4]. Escorts (family or friends) who accompany patients on their journeys are also often the focus of demand management. Some providers believe that provision of transport for escorts is another form of abuse.

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. However, patients in the other areas covered by the Ambulance Service – Cornwall and Somerset – are not charged. Westcountry Ambulance Service 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.

CASE STUDY 4

Eligibility initiatives: East Anglia

In two of the East Anglian Ambulance Service’s three county controls, health authorities have introduced new ordering systems with the aim of controlling demand. The Norfolk and Cambridgeshire health authorities organised project groups that contained all local trusts, community health councils, GP representatives and the East Anglian Ambulance Service. In the new system, flow charts are used to help control officers to check on demands being placed on the service. These systems were introduced after public consultation.

In Norfolk, GPs no longer order ambulances; all bookings are sent to hospitals for authorisation. Escorts are only carried if they are carers and the patient could not travel if the escort was not present. The impact of applying stricter controls at the Norfolk and Norwich Hospital NHS Trust has been to reduce demand by between 5 and 10 per cent – particularly in relation to C1 patients who require the assistance of at most one person and can travel by car.

In Cambridge, an officer has been employed by Addenbrookes NHS Trust to check all bookings and to make sure that all requests fit with hospital criteria. The post has stemmed any further increases in transport demand and costs as clinical services have developed within the hospital.

Source: Audit Commission
EXHIBIT 4

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’ (that is, ones provided 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.

42. Some ambulance service officers oppose any charging by their services because of fears about VAT complications and that their car services might lose the exemption from taxi and minicab licensing. The Audit Commission national report Going Places has therefore recommended that the Government review eligibility for non-emergency PTS and clarify when the NHS can charge patients for it.

43. Demand management remains difficult. Commissioners have problems with predicting transport demand, with actual volumes of activity exceeding or falling beneath the indicative levels set out in service agreements [EXHIBIT 5]. In-year information on transport demand patterns can help with the effective financial and operational management of the service; difficulties and sudden pressure to manage demand can stem from a lack of awareness of the volume of transport being used. Some hospitals depend on their transport providers to tell them how much service they are requesting.

44. The main problem with demand management is that most hospitals start managing too late – and normally only when indicative activity levels are exceeded. This tends to lead to draconian measures, including a halt on new orders, in attempts to claw back potential overspends.
EXHIBIT 5

Non-emergency PTS service agreements above and below indicative activity, analysed by ambulance services

For a substantial proportion of service agreements, actual activity is above or below indicative levels.

Source: Audit Commission, using data provided by the Ambulance Services Association (ASA). The ASA questionnaire was returned by 24 English ambulance services, but 2 did not provide the data used in this analysis.

45. To encourage cost accountability, Guy’s and St Thomas’ Hospital NHS Trust has devolved transport budgets to individual medical directorates. The Charing Cross Hospital NHS Trust, is currently experimenting with budgetary devolution [BOX K]. Hospitals that take this approach will need timely and structured data to help budget monitoring. But even if budgets are not devolved, similar data is required if commissioners are to monitor referral rates by individual clinics and GPs as part of demand management. Changes that are currently taking place in the wider commissioning framework – the expected transfer of responsibility for non-emergency PTS to Primary Care Trusts (PCTs) in England and the creation of Local Health Groups (LHGs) in Wales – may affect other hospitals’ willingness to take this step.

Financial support for access

46. The Hospital Travel Costs Scheme might reduce ‘social’ demand for free non-emergency PTS, but tends to be poorly promoted by trusts, even though NHS guidance states that:

- leaflets[II] on the scheme are to be freely available to patients in appropriate hospital departments or clinics, as well as in the community;

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II Leaflet HC11.
notices about the scheme should be displayed in all patient areas and details of the local arrangements for payments under the scheme should be displayed prominently in patient areas.

47. In one hospital visited, clinical department managers had only recently become aware of the scheme and wanted to promote this in an attempt to cut transport costs to their own department.

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**BOX K**

**The pros and cons of devolving transport budgets to clinical directorates**

Devolving budgets within the hospital encourages clinicians to consider the impact of their requests for patient transport services. There are several potential benefits:

- The clinical directorate becomes directly accountable for the budget for the service, and is in a position to manage it as it sees fit, making any necessary trade-offs between provision of non-emergency PTS and other medical needs.
- The directorate can monitor trends in patient numbers and spending on the service and quickly identify any problems.
- Budget management can lead to more flexible responses to changing requirements and allow different directorates to make locally informed changes to the service, for instance, to ensure that there is dedicated transport for discharges or for particular clinics at particular times.

Followed to its logical conclusion, devolving budgets may mean a need for more devolved and responsive commissioning practices. For example, it may be useful for elderly-care service managers to commission transport from a social services department, whose vehicles are unused in the middle of the day, for pre-discharge visits for their patients to nursing homes. This could help them to ensure that patients meet social workers or carers without impacting on or conflicting with other patient transport requirements.

The disadvantages of devolution are that:

- Different departments may manage demand in different ways and set their own criteria for eligibility, increasing the potential for inequity and inconsistency for patients.
- If budgets are devolved to inappropriate levels, unfair pressures may be placed on those departments.
- There may be little overall financial benefit for managers if they cannot use any savings on transport costs for other departmental spending.
- There is a danger of service fragmentation, particularly if individual departments seek alternative suppliers for their transport, creating the potential to lose the economies of scale achieved by bulk purchasing.

*Source: Audit Commission*

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1 A poster about the scheme – H10 – can be obtained from Department of Health, PO Box 777, London SE1 6XH.
Safety

48. Procedures to ensure patient safety are essential. Hospital commissioners should specify in their service agreements that all vehicles and associated equipment— including seatbelts, wheelchair lifts and wheelchair restraints—are safe, and comply with legal requirements. Commissioners should also insist that vehicles and equipment are operated correctly by properly trained staff; a simple error, such as failing to lock a wheelchair’s brakes before raising or lowering it in a tail-lift, could have disastrous consequences for a patient. Care also needs to be taken in assisting patients into and out of ‘carry chairs’, which are often used for transferring patients from their home to the vehicle. In one site visited during the Commission’s study, the driver did not remember to strap the patient into this chair until she asked for help. In addition, the chair was made of canvas, which was fraying, and lacked footrests.

49. Legislation requires that staff be security screened if they are in regular contact with children or vulnerable adults [BOX L].

50. Ambulance service non-emergency PTS crews should normally be trained to the NHS’s standard PTS crew requirement[II]. This means that, although travel time standards vary (see below), patient care on ambulances should be being provided to a common standard. Standards for other forms of provision, particularly voluntary car schemes and taxis, vary more than those for non-emergency PTS crews. For example, some agreements specify that Volunteer Car Service (VCS) drivers receive first aid training while others do not. Some ambulance services provide their volunteer drivers with mobile phones, with which to contact the service if passengers are taken ill during a journey; others do not. Specifications rarely mention training or standards for taxi drivers. Patient safety may thus depend on which type of transport is being used [BOX M].

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I A fatality recently occurred when an ambulance crew breached safety rules and failed to fit a wheelchair patient with a seatbelt.

II The quality of training of all ambulance crews is set and monitored by IHCD Health and Care Ltd on behalf of the Ambulance Service Association. IHCD Health and Care Ltd is the national awarding body for ambulance qualifications.
BOX L

Security screening staff

The Protection of Children Act 1999 requires that staff employed to work directly with children, or who provide services to children, should be security screened, against a national list of people unsuitable for such work, prior to appointment. Under these provisions it is necessary to check all staff in ‘regular’ contact with children. Current guidance states that:

‘It will be important for each organisation to consider the relevant posts that would fall under this definition. This may vary depending on the type of service delivery, for example, an A&E ambulance driver in an acute trust may not be included because he/she does not have regular contact with children. However, it may be appropriate to include a driver in a learning disability centre in a community trust, if he/she has regular contact with children...’

Organisations can now register with the Criminal Records Bureau, a new executive agency of the Home Office, which will carry out these checks for employers, although the service will not become fully operational until 2002.

The Care Standards Act 2000 also introduces new requirements for security screening staff who have regular contact with vulnerable adults. The Government is expected shortly to consult on guidance on the implications for this for health sector and other staff in regulated organisations.

Source: Audit Commission based on The Protection of Children Act 1999 and The Care Standards Act 2000

BOX M

Safety concerns

‘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 me treat straightaway [if complications arise].’

Renal patient

‘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].’

Volunteer driver

Source: Audit Commission focus groups

51. Many service agreements also specify how staff are to relate to patients [BOX N], as well as covering procedures for escorting or helping patients into and out of the vehicle. As the majority of PTS is undertaken by ambulance services, commissioners often rely on the integrity of these providers, as part of the NHS family, to adhere to safety and staff competency and training requirements set out in agreements. They often lack assurance, however, that these requirements are actually being met. Commissioners may only become aware of problems from complaints or casual observations of the service.

52. Commissioners are right to let ambulance services play a major role in quality control, but NHS guidance [BOX O] also makes it clear that commissioners should have quality assurance schemes of their own. Particular care should be taken where services are provided by private contractors and where volunteer car services are used. All commissioners should use their rights to carry out some unannounced on-the-spot checks on vehicles and equipment, including volunteer cars, taxis and hired cars and on training, maintenance and other records and contracts. Checks can legitimately be less frequent where commissioners are satisfied that provider arrangements are robust. But where service providers’ programmes of safety checks and fault-recording are less rigorous, more frequent random checking of vehicle safety by commissioners may be necessary. There should be sanctions in place for persistent safety breaches; service agreements should include appropriate financial penalties and incentives. In extremis, commissioners should be prepared to terminate agreements and re-tender.

BOX N

Expectations about patient care

Where necessary:

- Provide assistance to patients in preparing for the journey (for example, helping with outer garments).
- Remind patients to carry their medication with them, together with clinic documentation (for example, 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 while 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 examination of service agreements to which one ambulance service works
Improving systems can also help to address concerns about safety. For instance, ensuring that volunteer drivers have mobile phones allows them to seek help quickly if a patient becomes unwell during a journey or if there is a vehicle breakdown or other emergency. There are other possible benefits, for example, if all drivers have contact numbers for patients they are collecting, they can call ahead of arrival – and warn of any delays in pick-up times. One ambulance trust visited said it had a ‘running battle with a number of hospital trusts locally about the release of patient telephone numbers to the ambulance service, and that this was more often a problem where voluntary drivers are involved’. While patient confidentiality is important, this has to be balanced against the benefits of improving communication with patients and reducing their anxiety if the driver is likely to be late (thereby reducing patient calls to hospital reception staff, who may not know the length of likely delays).

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**Box 0**

Quality assurance

The Guidelines for Setting Non-urgent Patient Transport Standards written by Operational Research in Health and issued by the NHS Management Executive in 1990 state that:

‘It is the **PTS purchaser’s responsibility** to develop a Quality Assurance Plan (QAP) which specifies the standards of service required of the PTS provider within the terms of the contract. It is the **PTS provider’s responsibility** to install an appropriate Quality Control Scheme (QCS) which demonstrates that the required standards of service are being met. It is the **PTS purchaser’s responsibility** to monitor the PTS provider’s QCS and to make adequate arrangements for direct observation and measurement of service performance (both routine and sample). Any regular deviation from the ‘contract standard’ would initially result in discussions between purchaser and provider to resolve the problems identified. Persistent deviation from the contract standard could potentially result in penalties being imposed on the provider.

‘The Quality Assurance Plan (QAP) should be described in full in the contract; the Quality Control Scheme (QCS) should be described in full by the potential PTS provider in the tender return. The arrangements that the PTS purchaser plans to put in hand to ensure standards are being met are not disclosed in full to the PTS provider. These arrangements are termed Quality Assurance Scheme (QAS) and they are the **PTS purchaser’s responsibility**.’

*Source: Guidelines for Setting Non-urgent Patient Transport Standards, Operational Research in Health*

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II Correspondence from an ambulance trust to the Audit Commission, October 2001.
Standards for punctuality

54. There are at present no nationally agreed minimum quality standards for non-emergency PTS. The original Patients’ Charter contained one standard, that patients should wait no longer than thirty minutes from the time they were ready after an appointment, but its replacement does not mention patient transport. The NHS Plan and Improving Health in Wales make no direct reference to non-emergency PTS, and references within those National Service Frameworks that have been published are limited.

55. Standards – including safety, customer care, timeliness and travel time standards – for non-emergency PTS are currently, therefore, set locally by hospital trusts. Ambulance services thus typically work to varying standards set by different commissioners. The approaches followed are often influenced by the Guidelines for Setting Non-Urgent Patient Transport Standards II circulated by the NHS Management Executive in 1990 III. In some cases, hospital trusts and ambulance services continue to trade informally with little or no attention to written standards in service agreements. Where service agreements contain different quality standards for different clinics or sites, ambulance services’ quality monitoring systems may not be tailored to reflect these.

56. Both the Guidelines and local standards attempt to address issues that are central to most patients’ concerns – to manage 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 their appointments. Local standards are usually defined statistically or in terms of time bands [BOX P]. However standards need to more specific for some patients, such as those undergoing dialysis, where patients have fixed time slots and punctuality is important.

57. Sometimes the standards set are logistically unachievable – as both parties to the agreement know. The nature of the service provided means that the patients’ availability to travel, combined with traffic conditions, will inevitably result in failures to meet targets. For example, in many areas local afternoon clinics are difficult to service, because of late running morning clinics – vehicles are still taking morning patients home, when in theory they should be delivering new patients for afternoon clinics.

58. Some ambulance services collect travel time data, recording when patients are picked up and dropped off from vehicles. This means that they can monitor journey times and compare these with standards in agreements. This is increasingly accepted as useful practice by ambulance services and in-house transport operators. Guy’s and St Thomas’ Hospital keeps records of its monthly performance against targets, enabling it to analyse any changes and progress in meeting targets. However, the use of such data by those responsible for commissioning non-emergency PTS elsewhere is frequently poor. This means that the quality assurance and control responsibilities outlined in NHS guidelines [BOX O, earlier] are not always being adhered to. For example, at one ambulance service visited by the Commission, the post of quality assistant, responsible for collecting and analysing travel time data, was unfilled for

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I Your Guide to the NHS: see www.nhs.uk/nhsguide.


III These suggest issues to cover in local standards.
over six months when the previous post-holder was promoted. The ambulance trust received no formal queries from commissioning hospitals during this period, even though data on quality was not being sent to them.

Commissioners could benefit from re-examining the way service agreements are set up with providers, to address some of these issues and consider financial incentives for providers who meet or exceed quality standards.
Patient care and liaison

60. *The NHS Plan* and the *Improving Health in Wales* both emphasise the need for patient-centred services. In the transport context, this means that patients should be asked regularly whether current standards and arrangements are meeting their needs and, if they are not, to identify what improvements are needed. Commissioners should review and revise quality standards accordingly.

61. The Ambulance Service Association (ASA) non-emergency PTS committee intends to create a set of standard questions to ask in patient satisfaction surveys. If these are adopted widely, participating ambulance trusts will have the opportunity to make sensible performance comparisons – with each other, and over time.

62. At the more immediate level, a number of hospitals and ambulance services employ staff in local trouble-shooting roles who deal face-to-face with patients [CASE STUDY 5]. They can provide an important on-site link between hospital staff and the ambulance service staff, for example in responding to clinic cancellations and short notice discharges. At the Queen Elizabeth Hospital in Greenwich, a commissioning liaison officer and London Ambulance Service staff operate a non-emergency PTS desk together [CASE STUDY 6].

63. Hospitals should ensure that their complaints procedures are open and enable patients to put forward any problems. Some hospitals, such as Guy’s and St Thomas’, keep central records which enable them to analyse the type of complaints (for example, lateness or failures to book transport). For a true picture to emerge, staff should be encouraged to pass complaints to a central co-ordinator. It can be beneficial to develop a system which encourages the recording and monitoring of all compliments and complaints including informal ones.

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**CASE STUDY 5**

**Customer liaison: Greater Manchester**

Greater Manchester Ambulance Service has introduced ‘customer liaison officers’ who help to keep service users informed of progress while they wait for transport. They, rather than control staff, deal with complaints. They also play an important part in more strategic discussion of service delivery options, and in user consultation through:

- monthly monitoring of journey sheets;
- quarterly user forums; and
- six-monthly, one-to-one interviews in hospitals.

*Source: Audit Commission*
In addition to liaising with patients about their needs, attention should be given to the environment in which patients wait to be taken home, which is important to their comfort and well-being. Patients may need to take medication and, because of the tests or treatment they are to receive, may not have eaten before leaving home. Some hospitals, like Hammersmith Hospitals NHS Trust, 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 drinks. Others do not. The provision of such facilities may be important to some patients, such as diabetics who need to eat at certain times, but may also mean that patients are less likely to leave the waiting area for food and drink and then be unavailable when their transport is ready to leave. As the NAO has pointed out, 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 for other patients. Ambulance services point out that discharges can be held up because of issues beyond their control – for example, vehicles may have to wait while patients collect medicines from pharmacies.

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65. The availability of a lounge means hospital porters can bring patients to the lounge from wards, which is a more cost-effective use of labour than employing more highly paid PTS crews to move patients from wards, as typically happens when there is no lounge. Dedicated porters and wheelchairs, to help take patients to and from clinics, may also help to reduce delays and streamline the service for patients.

**Effective use of resources**

66. Hospitals will occasionally need more flexibility than some non-emergency PTS services currently provide [BOX Q]. In some cases, it may not be feasible or economical for an ambulance service to meet all non-emergency PTS demand. Segmenting different types of transport demands or patient groups and identifying the most appropriate provider to deliver each type of demand in these cases can be sensible.

67. Having separate agreements or contracts for different types of demand still allows a single provider to bid for all the work and to offer economies of scale. However, it also allows niche providers to bid. The commissioner can select from taxis or hired-cars, community transport or private suppliers, and choose whatever package of bids offers the best overall value. University Hospital Lewisham NHS Trust has separated its different non-emergency transport demands and in so doing has agreements with two different suppliers [CASE STUDY 8].

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**BOX Q**

**The need for flexible services**

‘Outside hours after 6.00 pm there are problems for people who need ambulances (not just walkers). We use minicabs for out-of-hours but on Friday and Saturday night there are problems because everyone in London wants cabs! If after 6.00 pm we ring transport when [patients] are ready – they charge for multiple journeys. If we need an ambulance we might have to wait for an A&E ambulance – we phone direct through ambulance control. This does not happen often – maybe once or twice a week – but it may increase because of the nature of the people we are seeing [who are less able-bodied].’

Senior renal nurse

‘We are always pressured for beds – if we identify someone to go home at 5.00 pm at the end of treatment it works well but if we need an extra unit of blood and they may stay until 8.00 pm this upsets the transport schedule. We could use taxis but we don’t have arrangements in place – it’s a question of how to pay. We have charged to clinical budgets for transport to get people in on occasion. Oncology daycare are using a subsidised taxi scheme for patients. [With discharges], we may be waiting for the bed for an A&E patient if an ambulance is late.’

Oncology doctor

Source: Audit Commission interviews with hospital staff
68. Hospitals, and commissioners of transport services within hospitals, have an interest in reducing the incidence of non-attendance not only because this misuses resources at hospitals, but also because it leads to aborted non-emergency PTS journeys, for which providers can charge. Based on ambulance service unit costs per journey, one in every three ambulance services responding to a survey by the Ambulance Service Association each received over £250,000 from hospitals, in 1999/2000, to cover the cost of aborted journeys [EXHIBIT 6].

EXHIBIT 6

The cost of aborted journeys
One in every three ambulance services providing data each received over £250,000 from hospitals in 1999/2000 to cover the cost of aborted journeys.

Source: Audit Commission, using data provided by the Ambulance Service Association (ASA). The questionnaire was returned by 24 English ambulance services. Data from 20 services was available for this analysis.

CASE STUDY 8

Segmenting non-emergency transport demand: Lewisham

University Hospital Lewisham NHS Trust has an agreement with a private supplier to provide non-emergency transport for all stretcher cases and its out-of-hours non-emergency patient transport. It has a separate agreement with Lewisham Borough Council’s Passenger Services department to provide non-emergency transport, within normal operating hours, for walkers and wheelchair patients.

Source: Audit Commission
69. The passing of details of cancelled appointments between hospital trusts and ambulance providers remains a significant problem. Where patients are expected to travel regularly – for example, to a weekly day hospital session – a hospital trust can set up a standing order for transport. But if the patient is too sick to attend, is admitted to hospital, or even dies, the ambulance will still call for the patient – unless either the patient, his or her family or carers, or the hospital advises the ambulance service to suspend or cancel the transport request.

70. However, although patients are asked to inform hospitals if they cannot attend appointments, they do not always do so. The NHS Executive reported that in 2000/01 patients failed to turn up for 14 per cent\(^I\) of total outpatient appointments. For inpatient and daycase treatment, about 5 per cent\(^{II}\) of patients failed to attend in 1998/99. In both cases some of these may have been due to transport difficulties.

71. Action by hospitals can improve overall attendance rates. More appropriate eligibility judgements about transport may help – some patients may find it difficult, or may forget, to attend if transport does not collect them. Some hospital call centres, which administer appointment bookings and cancellations, call patients in advance of their appointments to check whether they still plan to attend [CASE STUDY 9]. Often there is also scope to improve basic administration [BOX 8].

72. Another example of the direct influence of transport services – and the importance of local links between commissioners and providers – is in hospital discharge. As pressures on hospital beds increase, hospital managers report making more requests for transport at short notice to move patients from one hospital to another, or to take them home on discharge from either inpatient wards or accident and emergency (A&E) departments. They also report making more requests for discharges in the evenings and at weekends. Some ambulance services have met these demands by diverting resources from emergency and urgent work, potentially damaging their emergency response times and cross-subsidising non-emergency PTS from emergency budgets.

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**CASE STUDY 9**

‘Do-not-attends’ (DNAs) initiative: Trafford

An initiative to reduce non-attendance at Trafford General Hospital NHS Trust is also helping to save wasted trips for the Greater Manchester Ambulance Service. The hospital has funded a clerical officer to ring patients the day before their appointment and find out whether they intend to attend. This has both increased hospital attendance and reduced the incidence of PTS crews arriving to pick up a patient who is not planning to travel.

A similar scheme is expected in the South Tyneside Healthcare NHS Trust – a hospital served by the North East Ambulance Service.

*Source: Audit Commission*

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\(I\) Equivalent to 6 million patients. Data sourced from Department of Health, Hospital Activity statistics at www.doh.gov.uk/hospitalactivity/statistics/2000-01/hospital_activity_summary/yo0.htm.

73. Some hospital trusts, including several in Manchester and in the North East, are now jointly funding dedicated out-of-hours PTS. South Tyneside Healthcare Trust and the Musgrove Park NHS Trust in Taunton have both funded dedicated discharge vehicles as an ‘insurance policy’ [CASE STUDY 10]. Many metropolitan or city based ambulance services have sufficient work to support a 24-hour non-emergency PTS – hospitals are closer together and can share the ambulance resource. In rural areas, distances may be such that demands cannot easily be met by one vehicle working for several hospitals. In East Anglia, for example, there are, on average, just 30 non-emergency PTS requests each night between 10.00 pm and 7.00 am. These are generated by six hospitals across an area of 5,000 square miles. Out-of-hours coverage may cost more in such areas.

74. Service providers can also work with commissioners to improve the use of transport by zoning appointments. For example, day hospital services for the North East Ambulance Service are made easier by the practice of Newcastle General Hospital NHS Trust of taking patients from different estates in the city on different days of the week. This means that the Ambulance Service works mainly in one estate on one day and in another the next. Hospital trusts served by Warwickshire Ambulance Service have similarly co-operated to zone physiotherapy appointments. The zoning of clinics and patients to fit with non-emergency PTS operations may be difficult, however, to reconcile with individual appointment time initiatives within The NHS Plan.

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**BOX R**

**Reasons for delays and ‘Do-not-attends’**

Delays and non-attendance can result from poor communication. Examples include:

1. Poor record keeping by hospitals, for example out-of-date records, the patient has moved, the patient is deceased, or the appointment has been cancelled.

2. Other administrative errors, for example double booking of appointments, double booking of transport (two drivers arrive to collect one patient), or no booking at all; patient has not received appointment confirmation or confirmation that transport will be provided.

3. Failures to make bookings or to cancel them, due to forms being lost in hospitals.

4. An additional problem, particularly in rural areas, is that the driver may require detailed instructions on how to reach a remote address. Without the patient’s telephone number, so that the patient can provide directions, the driver may struggle to find the patient’s home.

*Source: Audit Commission*
Changes in the commissioning framework

Most ambulance services have a large number of different service agreements with hospitals, some of which are of relatively small value, worth under £50,000 a year. Each of these will have its own terms, quality standards and managerial overheads. Officers in ambulance services, interviewed by the Commission, have argued that this causes them to use resources inefficiently and that greater co-ordination of purchasing, and fewer service agreements would be preferable. On the other hand, more service agreements are likely to be needed to reflect greater choice, both at the hospital level and eventually at patient level.
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.

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.

76. This situation is likely to be exacerbated by the changes in the commissioning framework. In England, as part of organisational change under The NHS Plan to develop a more patient-centred health service, 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 responsibility for securing the provision of non-emergency patient transport services. The need to respond to these changes are discussed in the Commission’s national report Going Places.

77. In Wales, local health groups (LHGs) have been established within each area to provide a local focus for the development and improvement of health services. LHGs are currently committees of the health authorities. Health authorities are, however, to be abolished in Wales. Changes in commissioning structures for PTS may occur as a result of these developments.

78. In addition, changes in the way health services are provided – more specialism and more local delivery of care – and joint commissioning with social services will present challenges. Patterns of social care are also changing, with an increasing emphasis on individually tailored services. These changes will impact on when people travel to services, where they travel to and from, and who organises and provides their transport. The full impact of these changes is not yet clear but is likely to require greater flexibility in transport arrangements and more individually tailored requirements, with an increased emphasis on smaller vehicles and on transport outside the Monday to Friday working week.

* * *

79. This section looked at commissioning non-emergency PTS and the tensions between eligibility, the need to control expenditure and improving service quality. Where cost savings are made, commissioners may be able to invest in improving services. The questions in the following checklist will help commissioning trusts to balance these tensions.
# Self-assessment checklist for commissioners

## Stakeholder views

### The patient perspective
- Does the commissioning body consult/survey patients regularly for their views on the service? 
- Does its transport service meet their varying needs?
- Has it addressed any problems raised by patients?
- Is patient consultation reflected in service agreement/contract specifications?

### The hospital perspective
- Do GPs and staff booking transport in individual clinics and departments know how and when non-emergency PTS operates?
- Are GPs and representatives of individual clinics and departments consulted regularly on:
  - expected transport demand?
  - operating hours for the transport service (including out-of-hours and weekend provision)?
  - service quality requirements (including timeliness, safety, etc)?
- Is this consultation reflected in service agreement/contract specifications?
- Does the service meet the needs of those clinicians requiring transport?
- Does the commissioning body review these requirements periodically, including when service agreements/contracts are being re-tendered or renewed?
- Has it explored opportunities for joint commissioning of non-emergency PTS with other commissioners?

## Commissioning practices

### The principles of service delivery
- If the commissioning body has plans to alter its medical services, for example plans to extend clinic hours, has it considered how these will affect the demand for transport?
- Does the commissioning body take account of transport implications when considering service developments?
- Does it always consider vehicle accessibility when building new facilities?
- Has it discussed the implications of *The NHS Plan (or Improving Health in Wales)* with its service provider(s)?
- Has its service provider given any estimates of the likely additional costs of providing services that would match the aims of *The NHS Plan (or Improving Health in Wales)*?
- Do non-emergency PTS ambulance crews get sufficient recognition – from the commissioner – for the work they do?
- Does the commissioning body provide adequate accommodation for service providers?
**SELF-ASSESSMENT CHECKLIST**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Does it provide adequate parking space for non-emergency PTS vehicles during the day and for overnight storage?</td>
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<tr>
<td>Are non-emergency PTS crews made welcome?</td>
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<td>Are volunteer drivers welcomed?</td>
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<tr>
<td><strong>Local interpretations of eligibility</strong></td>
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<tr>
<td>Does the commissioning body have clear and equitable criteria for carrying patients?</td>
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<tr>
<td>Does it have clear and equitable criteria for carrying escorts?</td>
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<tr>
<td>Does it have clear arrangements for dealing with appeals and complaints about decisions on whether to provide free transport?</td>
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<td>Does its service provider always accept its decisions (as a commissioner) on eligibility?</td>
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<td>If all users of non-emergency PTS do not travel for free, is there a clear policy on charging?</td>
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<td>If so, has this been introduced after consultation with:</td>
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<td>- the health authority?</td>
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<td>- other stakeholders, including patients groups?</td>
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<tr>
<td>- the service provider?</td>
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<tr>
<td>Do charging arrangements cover patients entitled to reimbursement through the Hospital Travel Costs Scheme?</td>
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<td>Are there arrangements for exempting or offering discounts to frequent users (for example, renal patients and others who are receiving long-term treatment)?</td>
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<tr>
<td>Has the commissioner considered the implications of the scheme for escorts?</td>
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<td>Are there secure arrangements for handling money?</td>
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<td>Is there a clear audit trail for handling money?</td>
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<td>Does the commissioner know what income is generated from charging?</td>
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<td>Does any income generated exceed the true cost of its collection (the cost of money handling as well as public relations issues)?</td>
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<tr>
<td>Is this income reflected in the statement of accounts?</td>
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<tr>
<td>Has the commissioning body checked the VAT position with HM Customs and Excise?</td>
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<tr>
<td>Has it checked the taxi licensing position with the local taxi licensing authority?</td>
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<tr>
<td>Has it produced leaflets (targeted at patients) which explain how non-emergency PTS should be used?</td>
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<td>Is information sent to patients about the transport options when appointments are booked?</td>
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<tr>
<td>Has the commissioning body translated its eligibility criteria into workable protocols (flowcharts) for those who order transport?</td>
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<tr>
<td>Have staff applying these protocols received adequate training and guidance?</td>
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<tr>
<td>Is the budget for non-emergency PTS generated from reliable assumptions about:</td>
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</tbody>
</table>
SELF–ASSESSMENT CHECKLIST

- the impact of any known changes to service delivery?
- patient numbers?
- cost pressures on transport suppliers (for example, fuel and wage increases)?

Does the commissioning body profile the transport budget to take account of seasonal variations in demand?

Is outturn monitored against budget profile regularly and frequently by the budgetholder?

Are overspends identified, and acted upon, as they develop?

Does the commissioning body know the average cost of a journey?

Does it employ someone (for example, clinical staff or ward staff) to provide information regularly on non-emergency transport requests?

Does its service provider regularly provide it with information on usage of non-emergency transport?

Has it considered devolving transport budgets to individual medical departments and clinics?

Does it monitor referral rates by medical departments/individual clinics and GPs?

Financial support for access

Does the commissioning body operate the Hospital Travel Costs Scheme (HTCS)?

Are leaflets on the scheme freely available to patients in appropriate departments and clinics and staff informed on the scheme and able to advise patients?

Are notices about the scheme displayed in all patient areas (including GPs’ surgeries)?

Are details of the arrangements for payment under the Scheme prominently displayed in patient areas?

Are patients sent details of the HTCS with appointment confirmation letters?

Does the commissioner know how much the HTCS costs locally?

Safety

Do service agreements require providers to ensure that all vehicles, associated equipment and procedures are safe?

Do service agreements contain sanctions for persistent safety breaches?

Do arrangements adhere to NHS quality assurance and control procedures?

Is the commissioner satisfied that providers’ safety arrangements are robust, including arrangements for volunteer car schemes, taxis and other car services?

Where they are not, has it considered:
- increased monitoring of provider safety arrangements?
- carrying out more unannounced spot checks on provider vehicles, equipment and records?
**SELF–ASSESSMENT CHECKLIST**

### Standards for punctuality

Has the commissioning body set formal standards for customer care and journeys, covering:

- pick-up times?
- journey times?
- delivery to hospital?
- delivery home?
- comfort during the journey?

Does it require providers to monitor individual journey durations and to report this information to it?

Are there incentives in service agreements to promote service quality (for example patient care, punctuality and reliability)?

In addition to routine monitoring information (for example numbers carried by mobility type, distances travelled etc), does the service provider regularly send the commissioner quality monitoring information?

Are patients and other stakeholders’ views captured as part of the monitoring of service quality?

Is the commissioner generally satisfied with the quality of non-emergency PTS it is receiving?

Are patients happy?

Are GPs and clinicians happy with the quality of non-emergency PTS they are receiving?

Has the service provider identified the costs of improving quality?

Has the commissioner considered whether to invest in higher quality transport services?

Has it considered using other transport operators to improve quality?

### Patient care and liaison

Do the quality standards in service agreements/contracts reflect consultation with patients?

Is such consultation regular and continuing?

Is there a liaison officer (or equivalent) to deal with day-to-day service delivery problems?

Are all complaints monitored by the budgetholder/holders?

Do service agreements specify where service providers are to drop-off patients?

Has the environment in which patients wait to be taken home been reviewed?

Are there facilities for patients to:

- wait in comfort (both for when they arrive and when they are ready to be take home)?
- obtain food and drinks?
- have good access to toilets and phones?

Have patients been surveyed about these facilities?

Do hospital porters bring patients from wards to lounges?
### Self-Assessment Checklist

#### Effective use of resources

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there dedicated wheelchairs for transfers to and from wards?</td>
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<tr>
<td>Is the current service provider able to meet all of the demand for non-emergency PTS?</td>
<td></td>
</tr>
<tr>
<td>Has the commissioner considered using different providers to meet different types of demand?</td>
<td></td>
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<tr>
<td>Are there effective arrangements to limit aborted journeys (for instance, does all information on cancellations reach the service provider in time)?</td>
<td></td>
</tr>
<tr>
<td>Does the commissioner know the number of aborted journeys and what it pays for them?</td>
<td></td>
</tr>
<tr>
<td>Does it know whether transport problems are a significant contributory factor to inpatient and outpatient non-attendance?</td>
<td></td>
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<tr>
<td>Has it reviewed its eligibility criteria in the light of non-attendance?</td>
<td></td>
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<tr>
<td>Has it considered phoning patients in advance of their appointments to check whether they still intend to attend?</td>
<td></td>
</tr>
<tr>
<td>Are contractual arrangements for out-of-hours (including evenings and weekends) non-emergency transport clear?</td>
<td></td>
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<tr>
<td>Are contractual arrangements for out-of-area non-emergency transport clear?</td>
<td></td>
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</tbody>
</table>

#### Changes in the commissioning framework

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the commissioning body held discussions with service providers on the likely impact of changes in who commissions non-emergency PTS?</td>
<td></td>
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<tr>
<td>Has it considered the impact on transport of joint-commissioning with social services?</td>
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<tr>
<td>Has it considered the impact of changing patterns of social care?</td>
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<tr>
<td>Has it considered the impact of changes to where healthcare is delivered?</td>
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</table>
3. Providing non-emergency PTS

80. While commissioners shape service standards and set the framework for non-emergency PTS, they rely on providers for a patient-focused and cost-effective transport service. This section covers some of the issues providers need to address:

- **organising provision** – are we selecting the appropriate mix of vehicles?
- **costing and charging** – are we charging commissioners accurately for the services we provide?
- **delivering a flexible service** – are management practices, including booking systems, day-to-day operations, and management of volunteer car services, sufficiently flexible?
- **monitoring provision** – are we identifying changing trends in provision and providing necessary information to commissioners? and
- **responding to cost pressures** – are we successfully balancing costs and service quality, and achieving efficiency savings where possible?

81. The section concludes with a discussion of the changing framework of health and social care service configuration, and the need for further integration of transport services to meet these challenges.

Organising provision

82. Ambulance service trusts use a mix of ambulances and cars to meet demand. Cars include:

- taxi and hired-car services – these are typically used outside normal hours for work such as discharges from A&E Units, or evening or weekend transfers and discharges of inpatients; and
- voluntary car services – ambulance services often pay voluntary drivers mileage allowances intended to cover the additional motoring costs\(^1\) that volunteers incur.

83. Providers have to respond to a variety of transport requests. Most are advance bookings but others are booked at short notice; journeys may be either within normal operating hours or out-of-hours. Control centres have to handle bookings for both local journeys and journeys outside their normal ‘catchment’ area (out-of-area). When transport requests are made, commissioners normally specify patient mobility and the level of care required. Providers are then responsible for allocating patients to the safest and most appropriate vehicle. Patients may have different degrees of mobility and require different levels of assistance.

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\(^1\) These can include fuel, excess maintenance costs and excess depreciation.
Voluntary car services and taxis tend to be used for ‘out-of-area’ journeys or short-notice requests within normal operating hours (except for wheelchair, stretcher or high dependency cases which require ambulances and which may be sub-contracted to neighbouring ambulance services or delivered by private providers). For ‘out-of-hours’ journeys, some NHS providers use emergency ambulances – others spot-hire taxis, and, as discussed in the previous section, some now have dedicated out-of-hours vehicles.

Because service providers, particularly ambulance services, have a variety of options for meeting demand, they can configure their resources in different ways. Some – such as the London Ambulance Service – use dedicated staff, volunteers and vehicles for each commissioning hospital trust. Others, including Surrey Ambulance Service, pool resources between hospitals.

Providers need to ensure that they are providing a service that meets safety and other service standards; that staff – including volunteer car drivers and taxi and hired car drivers – are appropriately trained; and that vehicles are roadworthy, properly taxed and insured. Requirements to remedy vehicle defects as soon as they are identified can help to ensure that these do not put patients at risk – see Box O in the previous section for more details. Providers should also ensure that they meet other standards in service agreements.

Costing and charging

The NHS Finance Manual\(^1\) sets out financial guidance on both the provision of, and payment for, non-emergency PTS. The guidance also requires that agreements should cover longer periods than annual contracts; they should be based at least on a three-year rolling programme and be periodically reviewed with commissioners. They should also be signed. The guidance also requires commissioners and service providers to ensure that agreements are as comprehensive as possible, in order to minimise risks and reduce administrative costs. For this reason, service providers should ensure, wherever possible, that there are no ‘grey areas’; ‘out-of-area’ journeys or ‘out-of-hours’ journeys should normally be included, in service agreements.

Some commissioners and their providers have had difficulties predicting the numbers of patients to be carried and the mix of different mobilities. Uncertainty about volumes has created suspicions on both sides, with some NHS providers believing that commissioners deliberately understate volumes to achieve better prices. Conversely, some commissioners argue that providers have over-counted volumes to inflate prices. Budgetary constraints have also led many commissioners to negotiate price reductions as volumes have remained static or even increased.

There have been historic difficulties in costing non-emergency PTS. NHS providers are required to comply, when costing service agreements, with the principles of full cost recovery set out in the NHS costing manual\(^2\). It is important to properly distinguish non-emergency PTS costs from the costs of other activities, particularly the emergency ambulance service (which is currently paid for directly by health authorities). Some service providers find it difficult, with any accounting confidence, to estimate the true cost of providing a non-emergency patient journey.

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90. Some of the variation in costs, between ambulance services or between a single ambulance service’s agreements, is more attributable to different methods of costing than to differences in operating efficiencies. When ambulance trusts first tendered competitively for non-emergency PTS, their costs needed to be separated from those of emergency ambulance services. Some ambulance trusts adopted different costing methods for different agreements. And some services continue to roll forward their costing models from year to year without appraising whether the assumptions in the models are still valid.

91. Ambulance service mergers have added to the confusion. Some ambulance trusts, formed by mergers, are using radically different costing models, inherited from predecessors, in different service agreements, without amendment to reflect the new overheads bases created by the mergers. In these situations, services are unlikely to be recovering full costs from each hospital trust for which non-emergency PTS is being provided, and may therefore contravene NHS costing requirements. This likelihood is increased if the emergency service is carrying out out-of-hours or other non-emergency work and cross-subsidising non-emergency PTS.

92. There is a question over which ‘currency’ (for example, patient journeys or patient miles) to use in costing non-emergency PTS service agreements. The currency has to be readily understood and acceptable to commissioners (patient journeys is normally the easiest), but should also reflect the actual resources used (examples include patient miles or actual seats occupied). A number of services use ‘equivalent seats’, derived using weightings intended to reflect the number of seats occupied by each mobility category (for example, a single seat is attributed to a walking patient and two seats for a wheelchair patient). Whichever methodology is applied, NHS providers should satisfy NHS guidance by ensuring that costing systems are transparent, with clear audit trails.

93. There are allegations that, in the early stages of contracting, unit costs were artificially lowered, against NHS accounting rules, to win work. This created difficulties in relationships between some ambulance trusts, with suspicions of predatory or below cost pricing. Although strong inter-service competition for work continues in some areas, most ambulance trusts now have mutual understandings about where they will bid. While this may have led to a reduction in competition, it has also led to greater openness about costs and demand, and more creative discussion between providers and commissioners. It has also increased the willingness of ambulance trusts to take part in anonymised benchmarking.

**Delivering a flexible service**

94. As the NHS becomes more patient-focused, non-emergency PTS will need to become more flexible. The Commission received several comments from commissioners about the perceived inflexibility of ambulance services during its work. One requirement in *The NHS Plan* is for patients to select their own hospital appointment times. Where these systems are developed, links will need to be made to non-emergency PTS to ensure that any changes in demand patterns are not overlooked when appointments systems are changed. These changes will increase the challenges facing transport providers.
Delivering flexible services also involves:

- reviewing the notice required when taking bookings;
- managing day-to-day activity; and
- managing volunteer car services.

The notice required when taking bookings

Most ambulance trusts operate dedicated, telephone booking facilities for non-emergency PTS. It is common that bookings for transport have to be made up to 24 hours in advance,[BOX R] to allow schedulers to plan the use of staff and vehicles in advance. Some ambulance trusts have rigid deadlines and refuse requests for transport outside them, such as same-day bookings. This was one of several issues that prompted one hospital united to develop its own in-house provision. Other services are more accommodating.[CASE STUDY 11].

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**BOX R**

Examples of periods of notice

‘Under normal circumstances transport requests will not be received by the Service Provider after 1300 hours on the day prior to the transport being required, or after 1500 hours on a Friday prior to the following Monday. The Service Provider will, only in exceptional circumstances, try to accommodate transport requests received outside of these times, however acceptance cannot be guaranteed.’

* * *

‘The Patient Transport Control (PTC) will operate between 0800 and 1800 during weekdays. PTC will accept and guarantee the standards, for all bookings made and accepted before 1200 midday, of the day prior to the required transport date. PTC will continue to accept bookings after this time, but [these] will be identified as late bookings. They will continue to strive to attain the same standards in late bookings as for normal bookings, however, standards for late bookings cannot be guaranteed.’

‘All requests for [non-emergency] PTS journeys must be received by the Normal Minimum Booking Notice (NMBN) that is, by 1400 hrs the working day preceding the patient journey (1400 hrs on Friday for journeys required the following Monday).

‘The provider cannot guarantee the availability of resources to respond to ad hoc and short notice demands (that is, less than NMBN) and on the day bookings. It will, however, use reasonable endeavours to respond to these requests.’

Source: Audit Commission based on service agreements from two ambulance services
Managing day-to-day activity

97. The management and organisation of non-emergency PTS affects the timeliness of patient arrivals. For example, poor route planning, which does not take account of local road conditions, can lead to unrealistic planned journey times. Ambulance trusts should ensure that their booking systems record accurate information on all journeys made as well as on bookings and cancellations. They should monitor reasons for aborted journeys and follow them up with commissioners, for example, if inaccurate hospital records are a significant factor.

98. As noted earlier, several ambulance services now deliver non-emergency PTS outside normal working hours. Elsewhere, inflexible working arrangements result in emergency ambulances being used for such out-of-hours services, leading to cross-subsidisation and diverting vehicles and crews from emergency work. NHS providers should work with their staff sides to align resources with need. Alternatively, providers could subcontract this work.

Managing volunteer car services

99. Volunteer car drivers deliver a significant proportion of non-emergency PTS business, especially in rural areas. This use of volunteer drivers 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.’ Volunteer drivers should be treated as an integral part of non-emergency PTS, by both hospital and ambulance service staff, for example, receiving training and attending meetings with ambulance service staff.

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100. The East Anglian Ambulance Service has a pool of 350 regular drivers, the Westcountry Ambulance Service relies on 320 and the Greater Manchester Ambulance Service regularly uses around 40. But many ambulance services report that the number of regular volunteer drivers is falling. A number of factors have been offered to explain this, including a declining sense of civic pride and falling unemployment. Some managers also believe that responses to audit concerns about security of payment, income tax implications and the risk of false claims are also factors in the decline. Ambulance services should, however, always advise their volunteers of the need to comply with the law, and should make sure that volunteer drivers know about Inland Revenue rules for divulging income.

101. To be attractive to volunteers, it is important that mileage rates adequately cover their additional motoring costs, particularly in urban areas where drivers may spend long periods, with engines running, in traffic jams. Current rates vary between 25 pence and 40 pence per mile [EXHIBIT 8]. Depending on the engine size of their cars, volunteers need only to have driven relatively low mileages before they have to declare their income from the mileage allowances to the Inland Revenue [TABLE 1]. For example, a driver whose car engine size is within the 1001cc to 1500cc category and who is paid at 30 pence per mile, will need to declare this income once he or she has been paid for over 6,000 miles in a year. Rather than rely simply on standard mileage rates for volunteers, some NHS providers are considering other forms of reimbursement [CASE STUDY 12].

EXHIBIT 8

**Mileage rates paid to volunteer drivers**

Rates vary between 25 pence and 40 pence per mile

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**Source:** Audit Commission, using data provided by the Ambulance Service Association (ASA). The questionnaire was returned by 24 English ambulance services. Data is for 2000.
### TABLE 1

**Volunteer car drivers – declaration of income for tax purposes**

Some volunteers need only to drive relatively low mileages before they may become liable for income tax.

<table>
<thead>
<tr>
<th>If your total mileage for 2000-01 is</th>
<th>There is no tax to pay if you receive less than the following pence per mile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Engine size</td>
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<tr>
<td></td>
<td>Up to 1,000cc</td>
</tr>
<tr>
<td>2,000 miles</td>
<td>28p</td>
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<tr>
<td>3,000 miles</td>
<td>28p</td>
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<tr>
<td>4,000 miles</td>
<td>28p</td>
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<tr>
<td>5,000 miles</td>
<td>25p</td>
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<td>6,000 miles</td>
<td>24p</td>
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<td>7,000 miles</td>
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<td>18,000 miles</td>
<td>19p</td>
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<tr>
<td>20,000 miles</td>
<td>19p</td>
</tr>
</tbody>
</table>

*Source: Taken from Volunteer drivers (IR122) of the Inland Revenue Personal Taxpayer Series, Inland Revenue. The table is for 2000/01.*
Rather than use volunteers and pay them mileage rates to drive their own cars, Warwickshire Ambulance Service employs a number of staff who work directly from home [CASE STUDY 13]. This has helped the Trust to cut its pool of regular volunteer drivers from eighty to seven individuals.

CASE STUDY 12

Attracting volunteer car drivers: North East and Essex

In the North East Ambulance Service, approximately £1m is spent each year on the ambulance car service and its volunteer drivers. The Trust uses volunteers throughout its area, and supports the out-of-hours GP scheme with volunteer drivers. All drivers undergo systematic training and testing. The Trust pays 31p per mile, which is more attractive in the rural areas (where travel to hospital distances are typically long), than in the urban areas where distances are short. To make the task more popular in the cities in the north east, consideration is being given to paying a fixed amount (possibly 50p) for each patient collected and delivered in addition to the mileage reimbursement.

Essex Ambulance Service pays its volunteer drivers using a distance-banded price per patient (that is, within a distance band, drivers receive the same fee per patient, irrespective of how far they actually drive). Drivers are paid at 50 per cent of the patient rate for carrying escorts. The prices are derived from analysis of the average distance travelled per patient carried in the various distance bands and the mileage rate previously used by the Ambulance Service. They are updated annually.

The Service also makes ‘one-off payments’ for unreasonable (that is, very long journeys) and pays for escorts at the same rate as patients for travel to and from Great Ormond Street Hospital in London. The higher escorting payments help to make the work more attractive. The Service finds it particularly difficult to recruit volunteers for London journeys because of the slow traffic speeds in the capital. In this case both parents often accompany the child, meaning that the vehicle cannot take other patients at the same time, reducing driver’s income from payments for patients.

The arrangement is intended to maintain drivers’ incomes but also to be easier to administer. The price of a trip is generated automatically when trips are planned and patients are assigned to vehicles. Drivers accept the price when agreeing to take the trip; payment simply requires confirmation that the trip was made and the flat rate removes any opportunity for abuse (for example, by claiming inflated mileages or deliberately circuitous routing).

Source: Audit Commission
Monitoring provision

103. Good management information on service volumes, cost and quality is crucial to effective decision making and business planning by service providers. As well as information on the number of journeys undertaken for each commissioner, managers should also monitor the use of resources, for example, crew hours, vehicle mileage and fuel costs. This information should be SMART.

<table>
<thead>
<tr>
<th>Specific</th>
<th>Tailored to the needs of recipients.</th>
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<tbody>
<tr>
<td>Measurable</td>
<td>Information should be in the specified unit and for the specified time period.</td>
</tr>
<tr>
<td>Accurate</td>
<td>Information should be accurate.</td>
</tr>
<tr>
<td>Reliable</td>
<td>Information should be reliable.</td>
</tr>
<tr>
<td>Timebound</td>
<td>Information should be generated and distributed on a timely basis.</td>
</tr>
</tbody>
</table>

104. Although much of this management information is for internal use, service quality information and usage data may need to be passed to commissioners. The East Anglian Ambulance Service, for example, provides comprehensive numerical and graphical data on patient journeys to each of its non-emergency PTS commissioners within two weeks of the month end. It also provides specific exceptional reports requested by commissioners. Some services, in accordance with quality assurance guidelines [BOX L], also provide information on quality standards.

105. SMART usage information will enable non-emergency PTS providers to investigate the reasons for unit cost differences between service agreements. Better in-year monitoring of costs should lead to better pricing of service agreements. It is also good practice to participate in benchmarking, for example, through the Ambulance Service Association (ASA) non-emergency PTS committee [EXHIBIT 10].

CASE STUDY 13

Using remote drivers: Warwickshire

Home-based ambulance drivers are able to collect patients from their own areas more easily than sending a crew from a station. There is also less dead time and less dead mileage at the end of the day. Staff must have access to reasonably safe garaging or parking. Lists of jobs for the next day are faxed to the drivers’ homes, in the same way that some other ambulance trusts send job lists to volunteer drivers.

The Warwickshire Ambulance Service considers that the approach has been successful. As well as having more control over training and customer care, there have been improvements in the appearance of the vehicles. The Trust believes that the approach was one of the factors that enabled it to win a large contract in Birmingham.

Source: Audit Commission
**Variations in average patient journey costs, analysed by ambulance service**

A one-way non-emergency PTS journey typically has an average cost of £9.

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**Responding to cost pressures**

106. Health bodies have done much to ensure that they use transport resources effectively and efficiently, but may be under pressure to achieve additional year on year budget savings. Cost pressures can create conflicts with wider policy (for example, cutting costs by restricting access through stricter eligibility criteria may conflict with policies to increase social inclusion). The dilemmas within the health service about how to interpret the ‘medical needs’ criterion for free non-emergency PTS is an example of this.

107. There are opportunities to improve efficiency and achieve savings, for example:

- **Reviewing staffing arrangements.** Ambulance services should be seeking flexible working arrangements with their staff sides that align resources with demand. They should also seek to manage sickness levels.

- **Improving the planning of routes.** Some ambulance services still schedule manually. However, used appropriately, computer assisted scheduling systems – geographical information systems and other IT tools – can help to improve route design [CASE STUDY 14]. In theory the cost of planning systems should be built into unit costs. In practice this is rare, and ambulance trusts usually pay for this technology through their own efficiency savings, while commissioners get ‘free benefits’ from reduced cost operations.

- **Reviewing the use of taxis and hired-cars.** These have an important role to play in meeting needs, for example, for journeys that are difficult to predict and for low volume, out-of-hours work. Taxis and hired-cars do, however, have high costs per patient journey and continued large-scale spot hire is unlikely to be cost effective; it also increases opportunities for corruption. Formal contracts are likely to give better prices,
by offering suppliers guaranteed work. They can also help to encourage a higher quality service, by giving providers guaranteed workloads. They can include call-off prices for services required at short notices, as well as prices for scheduled work.

- **Greater co-ordination of services.** Providers should look outside the health service to improve transport services, so that, for example, local authority social services transport or community transport services can be better integrated with PTS. Co-operation between health bodies and local authorities on transport is rare. Exceptions include Lewisham Borough Council’s provision of non-emergency PTS for University Hospital Lewisham [CASE STUDY 15] and the arrangements being developed in Worcestershire [CASE STUDY 16].

### CASE STUDY 14

**Ambulance Service planning: Warwickshire**

Warwickshire Ambulance Service recognises that good planning is central to providing a good service and uses a computer system to produce a first draft plan of each day’s work. Planners then amend loads and routes based on their own local knowledge. The service estimates that using this method, the maximum number of patient trips that can be planned each day is around 750.

*Source: Audit Commission*

### CASE STUDY 15

**Integrating special educational needs transport with health service transport: Lewisham**

Lewisham Borough Council’s *Passenger Services* unit is an internal trading organisation that provides transport for the Council’s Education and Social Care and Health (that is, Social Services) Departments. The Education work is mostly 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 carries over 1,200 people a day, and uses vehicles ranging from estate cars to 45-seat coaches.

*Source: Audit Commission*
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. Ten community providers in Worcestershire received a total of £100,000 subsidy from the County Council, mostly for health-related journeys by elderly and disabled clients. 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 Health and Transport 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*
Changes in health and social care

108. Co-operation with local authorities offers the advantage of common standards of care, joint training, joint procurement and pooling of vehicles and spares, and staff. As more services are jointly commissioned, to meet the health and social care agenda, co-operation is likely to become more important. Full operational integration (that is, arrangements under which a vehicle is used for both non-emergency PTS and social services work on the same day) may further improve resource use, but this may also lead to difficulties. Changes to appointment, day-centre or clinic times, to facilitate transport integration, can have major implications for hospitals or social services staff and for patients, social services clients and their carers and may not be compatible with user and patient focus. Full integration can also create unwelcome interdependencies and reduce flexibility. The times at which clients leave the day centre have to dovetail with the appointments of non-emergency PTS, reducing the ability of the centre’s staff to adjust their programme of activities during the day. Improvements to efficiency also need to be balanced against patient focus in The NHS Plan and the Improving Health in Wales. For example changes to routing that increase technical efficiency – for instance, by maximising seat utilisation – may be unacceptable if they have an adverse impact on service quality, by increasing journey times.

109. Current variations in standards between local government and the health service act as a barrier to co-operation and the development of more integrated and seamless services. For example, local authorities usually insist that all their minibus-based services have forward facing seats, on safety grounds, as, in an accident, the risk of injury is greater with side facing seats. Some NHS providers have not yet fully phased out vehicles that have side-facing seats. Ambulance services should explore opportunities for co-operation with others. All such efforts should be aimed at delivering, as far as is possible, common standards of care. In Staffordshire, steps have been taken to integrate provision to meet the new demands of joint health and social care services [CASE STUDY 17].

CASE STUDY 17

Integrated health and social care and integrated transport: 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 hospitals 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 the transport 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
This section looked at arranging, managing and providing non-emergency PTS and the tensions between delivering a patient-focused service and the need to control expenditure. Providers will need to be flexible and work closely with commissioners. The following checklist will help providers to examine whether arrangements are in place to ensure cost effective service delivery.
### Self-assessment checklist for service providers

#### Organising provision

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Has the service provider reviewed how it allocates resources (vehicles and drivers) to different commissioners?</td>
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<tr>
<td>Has it considered subcontracting to other ambulance services or private operators to meet gaps in demand (for example, out-of-area or out-of-hours work)?</td>
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<tr>
<td>Are all staff, including volunteers, trained appropriately?</td>
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<tr>
<td>Are all non-emergency PTS crews trained to the appropriate IHCD standard?</td>
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<tr>
<td>Are taxi and hired-car drivers also appropriately trained?</td>
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<tr>
<td>Are there robust arrangements for ensuring vehicles and associated equipment are safe and comply with legal requirements?</td>
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<tr>
<td>Do these cover volunteers’ cars and taxis and hired-cars?</td>
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<td>Are fault-recording procedures adequate?</td>
<td></td>
<td></td>
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<tr>
<td>Are defects remedied immediately?</td>
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<td>Do vehicles contain all appropriate and necessary equipment?</td>
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<td>Does the provider undertake vehicle spot checks?</td>
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<td>Is there a vehicle age limit?</td>
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<td>Is this adhered to?</td>
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<tr>
<td>Are additional checks undertaken on older vehicles?</td>
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<td></td>
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<tr>
<td>Are volunteer drivers encouraged to have emergency breakdown cover?</td>
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</table>

#### Costing and charging

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do costing arrangements comply with the principles of <em>The NHS Costing Manual</em>, that is, are costs (and income):</td>
<td></td>
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<tr>
<td>- calculated on a full absorption basis?</td>
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<tr>
<td>- allocated and apportioned accurately by maximising direct charging and, where this is not possible, using standard methods of apportionment?</td>
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<tr>
<td>- matched to the services which generate them to avoid cross-subsidisation?</td>
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<tr>
<td>Can costs be analysed according to the minimum cost categorisation standard contained in <em>The NHS Costing Manual</em> (direct, indirect and overhead costs)?</td>
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<tr>
<td>Can costs be analysed by activity behaviour into fixed, semi-fixed and variable costs?</td>
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<tr>
<td>Are all overhead costs identified and a relevant proportion of these apportioned to non-emergency PTS cost centres?</td>
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<tr>
<td>Are the allocation and apportionment methods used periodically monitored and reviewed to ensure that they reflect actual cost usage?</td>
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</table>
## SELF-ASSESSMENT CHECKLIST

### Are costs accurately and consistently allocated and apportioned between service agreements?

### Is the ‘currency’ used in service agreements readily understood by and acceptable to commissioners?

### Do charges to individual commissioners reflect the actual usage and cost of the volunteer car service?

### Where emergency resources are used to deliver non-emergency work, does the costing system take account of this?

### Is there a proper and transparent audit trail for the costing of non-emergency PTS service agreements?

### As an NHS provider, does charging for individual journeys follow the guidance, in chapter 20 of *The NHS Finance Manual*, on which commissioners are responsible for meeting the costs of which types of non-emergency PTS journey?

### Are service agreements with commissioners as comprehensive as possible as required by *NHS Finance Manual* guidance (Chapter 20, para 20.27)?

### Delivering a flexible service

### Has the service provider considered transport issues arising from *The NHS Plan* (or *Improving Health in Wales*)?

### Has it discussed the implications of *The NHS Plan* (or *Improving Health in Wales*) with its commissioners?

### Have commissioners provided it with any estimates of the likely additional demand for non-emergency transport, and the changes in how it will operate, that will be required to meet *The NHS Plan* (or *Improving Health in Wales*)?

### Are managerial responsibilities for each agreement clear?

### Is there a formal complaints system for transport patients (separate from any system the commissioner may have)?

### The notice required when taking bookings

### Do the agreements with commissioners cover the booking times for journeys?

### Are bookings taken on the same day, or at short notice?

### Managing day-to-day activities

### Is the level of abortive journeys monitored for each commissioner?

### Are the reasons for aborted journeys monitored?

### Are commissioners provided with timely information on the level of and reasons for aborted journeys?

### Have commissioners been offered dedicated discharge services?

### Have the costs of extending the operating hours of the service for each commissioner been identified?

### Have the costs of improving service quality for each commissioner been identified?
**Managing volunteer car services**

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Are there enough volunteer drivers?</td>
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<td>Has the option of employing full-time drivers instead been considered?</td>
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<tr>
<td>Do volunteer mileage rates need review (in response to difficulties recruiting volunteers)?</td>
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<td>Have other arrangements for paying volunteers been considered?</td>
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<tr>
<td>Is the recruitment of volunteers targeted (for example, voluntary bodies, networks of carers and sufferers, or from local bus companies' early retirement programmes)?</td>
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<tr>
<td>Before volunteers first carry patients, are there effective systems to check and record that vehicles:</td>
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<tr>
<td>● are of the appropriate standard and type to carry patients (for example, four-door, if carrying more than one patient)?</td>
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<td>● are well maintained?</td>
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<td>● have a valid MOT?</td>
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<td>● are taxed?</td>
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<tr>
<td>● are insured (covers the driver for carrying patients, and covers carriage for hire where patients are charged)?</td>
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<tr>
<td>Is this information rechecked periodically?</td>
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<tr>
<td>Are volunteer drivers:</td>
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<tr>
<td>● security checked before they first carry patients (where required by the Protection of Children Act 1999 and the Care Standards Act 2000)?</td>
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<tr>
<td>● given necessary contact information and details of the needs of each patient before they first carry that patient?</td>
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<tr>
<td>Is there an age limit for volunteer drivers?</td>
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<td>Is it adhered to?</td>
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<td>Is there an age limit for volunteers’ vehicles?</td>
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<td>Is it adhered to?</td>
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<td>Are volunteer drivers required to undertake a driving assessment?</td>
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<td>Is the medical and physical fitness of volunteer drivers assessed?</td>
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<tr>
<td>Are volunteer drivers issued with written guidance to cover their duties in accordance with service agreement specifications and quality standards, which may cover specifics such as:</td>
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<tr>
<td>● the level of assistance to patients in preparing for the journey?</td>
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<tr>
<td>● providing assistance, with or without the use of wheelchairs/carrying chairs, in and out of the house, hospital departments and vehicle?</td>
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<tr>
<td>● ensuring that patients are not left unattended while negotiating steps or stairs and when entering or alighting from the vehicle?</td>
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<td>● standards of dress and presentation?</td>
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</table>
### SELF–ASSESSMENT CHECKLIST

- other behaviour (for example, codes of conduct, smoking on duty; behaviour when waiting for patients)?

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<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Are volunteer drivers provided with relevant training (such as first aid, manual handling, disability awareness and customer care training)?</td>
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<td>Are volunteer drivers provided with and required to carry photocard/identity badges?</td>
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<td>Are volunteer drivers welcomed and treated as an integral part of the broader service?</td>
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<tr>
<td>Are communication arrangements, between volunteers and PTS planners/controllers, clear and effective?</td>
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<tr>
<td>Do volunteer drivers know what to do and who to contact if a patient becomes unwell while on a vehicle?</td>
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<tr>
<td>Are volunteer drivers satisfied that they are adequately trained and equipped to deal with emergencies?</td>
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<tr>
<td>Are patients satisfied with the quality of the voluntary car service?</td>
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<tr>
<td>Are there effective arrangements for dealing with complaints about transport provided by volunteer drivers?</td>
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<tr>
<td>Where staff or volunteers are required to handle cash as part of their duties, are arrangements and controls are adequate?</td>
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<td>Are auditors satisfied with these arrangements?</td>
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<tr>
<td>Are journeys claimed by volunteer drivers sample checked before claims are authorised?</td>
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<tr>
<td>Are mileages claimed for individual journeys checked for accuracy, or to see that they represent a reasonable route, on a sample basis, before claims are authorised?</td>
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<tr>
<td>Are drivers informed about Inland Revenue requirements?</td>
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<tr>
<td>Is there a database (and audit trail) of volunteer driver activity (journeys and miles) and claims by:</td>
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<tr>
<td>- volunteer?</td>
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<td>- commissioning trust?</td>
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### Monitoring provision

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<th>Question</th>
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<tbody>
<tr>
<td>Is the deployment of resources monitored?</td>
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<tr>
<td>Do management information systems capture and report SMART activity and cost information?</td>
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<tr>
<td>Do commissioners regularly receive activity and quality monitoring information?</td>
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<tr>
<td>Are service standards agreed with commissioners?</td>
<td></td>
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<tr>
<td>Is performance against standards checked or monitored by commissioners?</td>
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<tr>
<td>Is the provider regularly monitoring its own performance against these standards?</td>
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<tr>
<td>Are there financial penalties if the service does not meet quality standards?</td>
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<tr>
<td>Do patient satisfaction surveys form part of performance monitoring?</td>
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<tr>
<td>Are costs (total and unit) monitored at individual commissioner or service agreement level?</td>
<td></td>
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<tr>
<td>Are the reasons for differences in unit costs, where these exist, understood?</td>
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<tr>
<td>Self-Assessment Checklist</td>
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<tr>
<td>Does the provider participate in benchmarking with other transport services (NHS, local authority or private), at least annually? ( )</td>
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</table>

**Responding to cost pressures**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Do changes in staff terms and conditions need to be agreed with the staff side to help to provide a more flexible service?</td>
<td>( )</td>
</tr>
<tr>
<td>Is the provider working with staff sides to achieve this?</td>
<td>( )</td>
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<tr>
<td>Can computer-assisted scheduling systems and other IT tools improve route planning?</td>
<td>( )</td>
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<tr>
<td>Do planners periodically go out ‘on the road’ to familiarise themselves with route and local traffic conditions?</td>
<td>( )</td>
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<tr>
<td>Has use of taxis and hired-cars been reviewed?</td>
<td>( )</td>
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<tr>
<td>Are there formal contracts with taxi or hired-car operators?</td>
<td>( )</td>
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<tr>
<td>Has the provider pursued opportunities to work more closely with, or integrate services with, local authorities and others, including community transport providers?</td>
<td>( )</td>
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</tbody>
</table>

**Changes in health and social care**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Has the provider considered the implications of joint commissioning of health and social care services?</td>
<td>( )</td>
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</tbody>
</table>
4. Conclusion

111. Non-emergency PTS plays a key role in allowing people to access health services, including some of the most vulnerable and disempowered people in modern society – children, elderly people and adults who are ill or who have physical or other disabilities – as well as more able-bodied people. Managed effectively, non-emergency PTS thus contributes to promoting social inclusion.

112. There are many examples of good practice and many good hard working health service staff and contractors. But there are also opportunities for both quality and efficiency improvements. At present, commissioners often view non-emergency PTS as diverting resources from clinical care, rather than seeing its importance as part of the overall healthcare package. At the same time, staff in non-emergency patient transport services are often have low status within ambulance services. In reality, PTS crews have more contact with patients than their paramedic colleagues, and play an important role in helping the NHS to deliver patient-focused services. Some ambulance services have made real efforts to enhance the status of non-emergency PTS, no longer using hand-me-down vehicles from the emergency service, and ensuring paramedics work on PTS as part of their training. Elsewhere, a change in attitude is needed among both commissioners and providers if PTS services are to further improve. The Audit Commission’s national report Going Places describes what central government can do to improve the framework within which health bodies work. However there is much that health bodies can do within the current framework to build on existing good practice to provide safe, effective, flexible transport arrangements that provide fair access to vital health services. The table opposite [TABLE 2] sets out the main points, which involve an holistic, co-operative, patient-focused transport service, that pays appropriate attention to service standards as well as to finance and cost.
### TABLE 2

**Action by health bodies**

<table>
<thead>
<tr>
<th>COMMISSIONING BODIES SHOULD:</th>
<th>THIS WILL:</th>
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<tbody>
<tr>
<td><strong>Improve patient-focus</strong></td>
<td></td>
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<tr>
<td>Treat transport arrangements as central to access to services</td>
<td>Help to meet the access requirements in <em>The NHS Plan and Improving Health in Wales</em></td>
</tr>
<tr>
<td>Treat appropriate provision of free transport as part of the package of healthcare</td>
<td>Improve patient-focus and reflect the requirements of the current guidance</td>
</tr>
<tr>
<td>Publicise the Hospital Travel Costs Scheme adequately</td>
<td>Implement current guidance</td>
</tr>
<tr>
<td>Survey patients’ views regularly. Also survey medical staff to obtain their views about non-emergency PTS</td>
<td>Identify whether current arrangements meet patients’ needs and, if they do not, identify what improvements are needed to create quality, patient-centered arrangements</td>
</tr>
<tr>
<td>Review quality standards after consultation with patients</td>
<td>Help to ensure that services meet patients’ needs and expectations</td>
</tr>
<tr>
<td>Revise quality standards where necessary, to reflect those views, and publicise them locally</td>
<td>Help to ensure that safety and quality standards are met</td>
</tr>
<tr>
<td>Monitor performance and publicise how it compares with standards</td>
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<tr>
<td>Use contracts/agreements that encourage and reward achievement of standards</td>
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<tr>
<td><strong>Improve the status of non-emergency PTS</strong></td>
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<tr>
<td>Treat non-emergency patient transport as a core part of the NHS</td>
<td>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</td>
</tr>
<tr>
<td><strong>Work with others to improve the service</strong></td>
<td></td>
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<tr>
<td>Explore options for improving patient focus, efficiency and effectiveness in partnership with ambulance services, local authorities and others</td>
<td>Identify opportunities to make savings and to provide customers with integrated, patient- and user-focused services</td>
</tr>
<tr>
<td><strong>Review funding</strong></td>
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<tr>
<td>Set realistic budgets that reflect demand and service standards and monitor expenditure regularly and effectively</td>
<td>Take account of service standards when setting budgets and reduce the likelihood of budget overspends</td>
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<tr>
<td>Do so taking account of the impact of non-emergency PTS on ‘did not attend’ rates and on discharge delays</td>
<td>Set budgets that take account of how non-emergency PTS contributes to the effective use of NHS resources</td>
</tr>
<tr>
<td><strong>Plan for change</strong></td>
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<tr>
<td>Review how non-emergency PTS and its funding need to change in response to the challenges ahead</td>
<td>Ensure that arrangements respond to changes in healthcare and social care and to joint commissioning</td>
</tr>
<tr>
<td><strong>AMBULANCE SERVICE SHOULD:</strong></td>
<td><strong>THIS WILL:</strong></td>
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<tr>
<td>Work with commissioners on the above agenda</td>
<td>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</td>
</tr>
<tr>
<td>Continue to explore opportunities to make better use of resources and to improve value for money without compromising safety or patient-focus</td>
<td>Ensure that public money is used effectively</td>
</tr>
</tbody>
</table>

*Source: Audit Commission*
Index References are to paragraph numbers, Boxes and Case Studies and Appendices (page numbers)

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
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<tbody>
<tr>
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<td><strong>Benchmarking</strong> 93, 105</td>
<td><strong>Carers</strong> 20, 41, 108, Box B (p9), Box F (p20), Box I (p24), Box K (p32), Case Study 4 (p29)</td>
<td><strong>Devon</strong> 4, 41; Case Study 1 (p10)</td>
<td><strong>East Anglian Ambulance Service</strong> see Ambulance service(s)</td>
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<tr>
<td><strong>Assessment</strong> 1, 2-6, 68, 89, 110; Box H (p61)</td>
<td><strong>Budget</strong> 31, 34, 45, 72, 106; Box Q (p41)</td>
<td><strong>Care Standards Act 2000</strong> Box L (p34)</td>
<td><strong>Dial-a-ride</strong> 12-13, 15; Box E (p14)</td>
<td><strong>Emergency</strong> 53, 72, 84, 91, 98, 112 see also Accident and emergency</td>
</tr>
<tr>
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<td><strong>Charing Cross Hospital NHS Trust</strong> see Hospital trusts</td>
<td><strong>Driver(s)</strong> 48, 100-101; Box A (pp6-7), Box E (p14), Box G (p21), Box L (p34), Box M (p34), Box R (p44); Case Study 12 (p60); Case Study 13 (p61) see also Volunteer driver(s)</td>
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<tr>
<td><strong>Accident and emergency (A&amp;E)</strong> 72, 82; Box A (pp6-7), Box L (p34), Box Q (p41); Case Study 6 (p40), Case Study 10 (p45), Case Study 11 (p57)</td>
<td><strong>budget monitoring</strong> 45</td>
<td><strong>Competition</strong> 93</td>
<td><strong>Driving licences</strong> 10</td>
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<td><strong>Addenbrooke’s NHS Trust</strong> see Hospital trusts</td>
<td><strong>devolving budgets</strong> 45; Box A (pp6-7); Box K (p32)</td>
<td><strong>Complaints</strong> 22, 51, 63; Box A (pp6-7), Box F (p20); Case Study 5 (p39)</td>
<td><strong>East Anglian Ambulance Service</strong> see Ambulance service(s)</td>
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<td><strong>Age Concern London</strong> 14</td>
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<td><strong>Elderly</strong> 10, 13-14, 17, 111; Box A (pp6-7), Box I (p24), Box J (p25), Box K (p32); Case Study 16 (p64); Exhibit 3 (p13)</td>
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<tr>
<td><strong>Ambulance car scheme</strong> see Voluntary car scheme</td>
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<td><strong>Emergency</strong> 53, 72, 84, 91, 98, 112 see also Accident and emergency</td>
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<tr>
<td><strong>Ambulance service(s)</strong> 29, 36-38, 41-42, 50-53, 55, 58, 62, 65, 68-69, 72, 75, 80, 82, 84-85, 90-91, 94, 98-100, 107, 109, 112; Box A (pp6-7), Box E (p14), Box H (p22) Box M (p34) Box P (p38); Case Study 6 (p40); Exhibit 1 (p4), Exhibit 2 (p4), Exhibit 4 (p30), Exhibit 5 (p31), Exhibit 6 (p42), Exhibit 7 (p46), Exhibit 8 (p58), Exhibit 10 (p62)</td>
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<td><strong>Escorts</strong> 40; Box D (p12); Case Study 4 (p29), Case Study 12 (p60)</td>
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<td><strong>Essex Ambulance Service</strong> see Ambulance service(s)</td>
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<td><strong>Emergency</strong> 53, 72, 84, 91, 98, 112 see also Accident and emergency</td>
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<td><strong>Expenditure</strong> see also Costs</td>
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The Special School Run
Reviewing Special Educational Needs Transport in London
There are useful lessons to be learnt nationally from this London-based study examining special educational needs (SEN) transport. This report focuses on helping authorities to improve their home-to-school transport for children with SEN. It includes comparative information on policies, arrangements and costs across London and a self-assessment checklist.


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. Charging with Care will be of interest in the wider debate surrounding the funding of long-term care.


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.


The Audit Commission has produced a number of reports covering issues related to police services and general management. The following may be of interest to readers of this report:
Non-emergency patient transport takes an average of over 30,000 people to hospital every working day and costs health bodies over £150 million a year. While often seen as diverting resources from front line medical care or from emergency ambulance services, this transport is essential to assist sick people, who may have no other means of getting to treatment. The service thus plays an important role in promoting social inclusion. It can also contribute to the environmental agenda, by reducing the use of cars.

Currently, while many patients are happy with their service, others have concerns. These centre on delays in getting to hospital, long waits for transport after treatment, which can affect people's ability to take food and important medication, and a lack of information about delays. People's eligibility for transport also varies across the country, and, in some cases, patients are charged for transport while, in other areas, people with similar conditions and personal circumstances receive free transport.

There are opportunities to improve the patient-focus of non-emergency PTS services, and to develop better co-ordination of arrangements between the NHS and other transport providers, including councils and community transport organisations. Arrangements also need to respond to new challenges, including the joint commissioning of health and social care, changing commissioning structures in England and Wales and changes in where medical care is delivered.

This handbook offers practical advice to those responsible for commissioning non-emergency PTS and for policy on, and eligibility for, this service. It will also help those ambulance services and other operators that arrange and provide the transport. It includes a series of self-assessment checklists and examples of good practice for them to review their provision.

Three other handbooks in this series offer guidance on other transport services – travel to social services facilities, special schools and mainstream education. The overall issues raised are also addressed in a national report, *Going Places: Taking People to and from Education, Social Services and Healthcare*. This suggests how central government can help commissioning bodies and ambulance services by reviewing the framework within which they work and ensuring equal access to non-emergency patient transport.