JONATHAN BRAY

Put some blue lights on Total Transport

Trials have shown that bringing together transport resources can bring benefits and savings, so why is the NHS dragging its feet?

Stand on any street corner and it won't be too long before some form of public sector funded collective transport vehicle passes by, be it regular public transport or be it connected to healthcare, social services or education. Yet these different services are orchestrated by different bureaucracies, different funding streams, different vehicle fleets, and sometimes generate different profit streams. At a time when public funding is so stretched an observer from another planet would say "why on earth would you waste public money in this way?".

Hence the recent enthusiasm for Total Transport pilots designed to realise savings and synergies by combining vehicle fleets, budgets, bureaucracies - or some combination of all three. However, some of these pilots are being held back, or are even grinding to a halt, because of the lack of interest and real commitment from the NHS in putting non emergency patient transport services into the Total Transport pot. It's not as if the NHS in general is particularly good at non emergency patient transport. All too often it's a high cost service, with inappropriate vehicles providing an inflexible, unreliable and inconsistent service to those who rely on it.

"The failure of the NHS's own bespoke transport operation costs the NHS money"

NHS patient transport services at the Royal Berkshire Hospital

For example, a survey in London found that 37% of those questioned had missed an appointment because of patient transport services. As well as the stress and angst that must have caused the patients concerned, here is a service that has one job to do (get patients to appointments on time) and manages to spectacularly fail to do so on a regular basis. And with the cost to the NHS of missed appointments estimated to be £750m a year the failure of the NHS's own bespoke transport operation costs the NHS money it could be using to get on with the job it really likes doing, which is mending people.

We ran some maths on this as part of a recent report we produced with the Community Transport Association (supported by ATCO, the Association of Transport Co-ordinating Officers) which found that if by providing patient transport in a more efficient way we could prevent just 10% of the 5.6 million missed hospital appointments every year then that would pay for 83 new MRI scanners (£895,000 each), or 8,793 heart bypass treatments (£8,470 each), or 13, 252 hip replacement treatments (£5,620 per treatment).

So how is it possible that the NHS says it is short of funding, but is offered a way to save money, which it then shows very little interest in? I suspect turkeys not voting for Christmas is one key factor. The people in charge of non emergency patient transport services at present in the NHS, not surprisingly, may be thinking what's this going to mean for me and my staff if these changes go ahead?

I also suspect that people don't join the NHS to sort out transport logistics. It's not really the heroic image that people have in mind when they think about a career in healthcare. This combined with the scale of the NHS budget, (which dwarfs that of smaller countries' entire budgets), the constant organisational churn and the thousand and one other problems that NHS leaders must face when they check their emails, means that transport logistics are nowhere near the top of anybody's priorities.

And when they do think about it there are no doubt concerns that splitting non emergency from emergency patient transport will affect the economics of the latter. And there are of course real challenges in making total transport

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schemes work in practice. There are very good and obvious reasons why pooling makes sense. But equally there are good reasons why they are currently provided separately (given the differing clienteles and their needs).

However, that's what pilots are for. To see if these ideas can work in practice. And there are some working examples that show what's possible. Which is at least some improvement on the verdict of a Department for Transport report in 2013 which found that despite the potential benefits, integrated approaches to organising local authority transport and non emergency patient transport services were still largely "non-existent".

So, for example, West Berkshire Council is now providing accessible minibuses from their in-house fleet and trained driver resource to and from hospitals and other healthcare facilities in Berkshire, Oxfordshire and Swindon, as a sub contractor to the South Central Ambulance NHS Trust. This initiative has ensured that those using the service are able to attend appointments at diverse healthcare facilities in West Berkshire and its environs. In doing so it's also led to much better utilisation of the council's own vehicle fleet in the lull between its peak time use for social care and schools transport. The benefits reinforce each other - more efficient use of council resources, a better service for patients, and less pressure on an ambulance service which can focus more on the work it needs those blue lights and sirens for.

Or take Devon County Council, which has expanded the remit of its in-house transport coordination service (which manages public transport support, education and social services transport as well as its in-house fleet) to include non emergency patient transport. The service now also assesses eligibility for patient transport and signposts non-eligible patients to other ways of getting to appointments.

And that's why all the excuses for foot-dragging we have seen so far from the NHS more widely on the pilots aren't enough to excuse the inactivity. Health people like fixing people (for example, there is no culture in the NHS of organising anybody's appointments with an eye to how people might get to the appointment) and transport people like fixing transport problems. So why not let transport people see if they can do a better job? The NHS can get on with doing what it's good at, patients won't have to worry so much about how they get to those vital medical appointments, and ambulances can make the best use of all that expensive equipment and on board expertise to deal with real emergencies - rather than acting as massively over-specified taxis.

Hopefully the report we have produced, with our friends at the Community Transport Association, provides the ammo that the Treasury and DfT need to chivvy the Department of Health into putting some flashing blue lights on an idea that could bring benefits and savings across sectors and to real people in real need. ■

ABOUT THE AUTHOR

Jonathan Bray is the director of the Urban Transport Group. Throughout his career in policy and lobbying roles he has been at the frontline in bringing about more effective, sustainable and equitable transport policies.