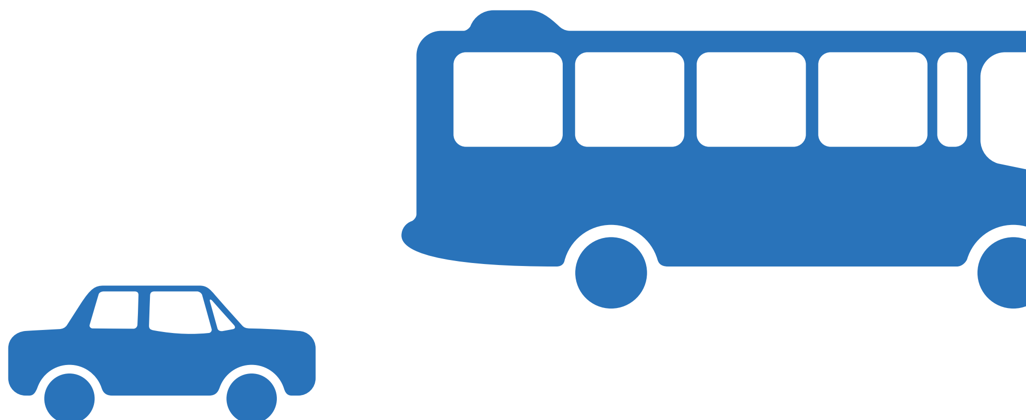
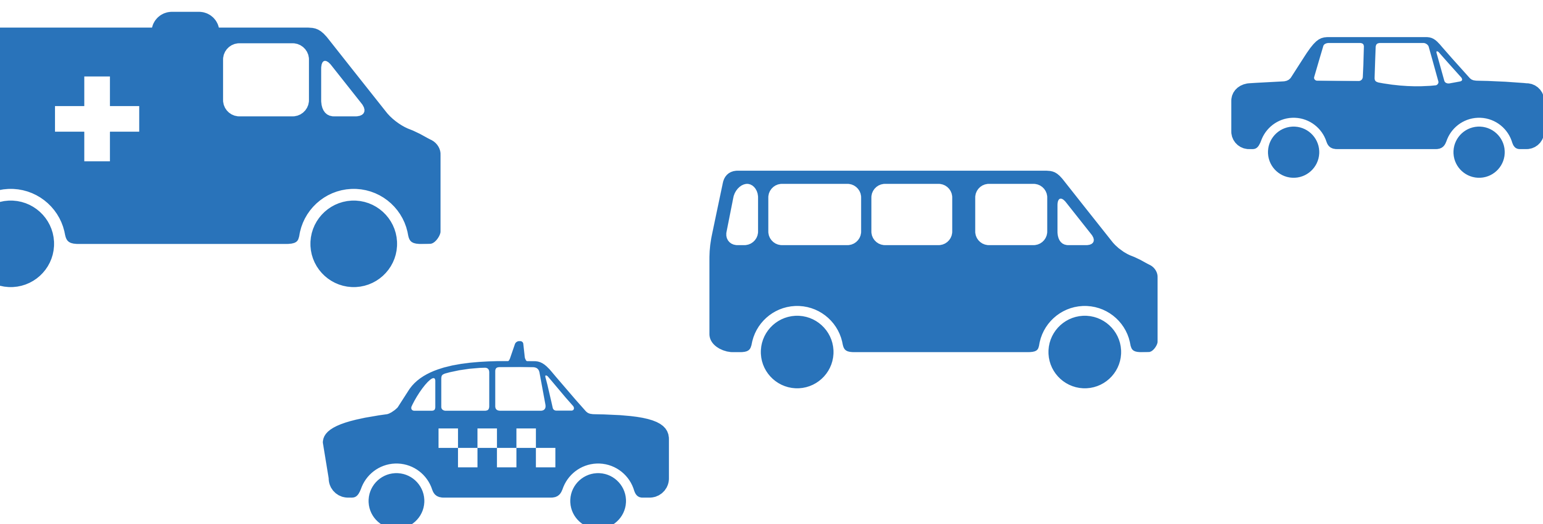
NHS
Eastern and Coastal Kent



"Commissioning Transport for health"

Summary report of Workshop, held 18th May 2009



NHS
Eastern and Coastal Kent

"Commissioning Transport for health"

Summary report of Workshop, held 18th May 2009

1. Introduction:

Transport, (particularly non-emergency patient transport) to healthcare facilities has been a key issue for patients, the public, visitors and staff alike in recent years. Transport generally is not core business for health providers, but has a major impact on the patient's experience of healthcare. This workshop, the process and outcome of which is outlined in the attached report, explored what the key issues were, developed an outline of three key projects to take forward with partners, and prepared the local NHS to participate in a wider inter-agency event, to be led by Kent County Council in the near future.

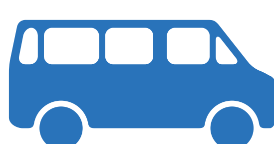
2. Report of workshop, including

- presentations;
- group discussions 1
- plenary session – three projects to develop
- group discussions 2 – scoping the projects
- workshop recommendations to PCT commissioners
- evaluation/feedback on the event

3. Appendices:

3.1	list of attendees
3.2	copies of overheads
3.3 A and B	write-up from flip charts of discussion groups
3.4	summary of feedback/evaluation
3.5	the importance of transport to the NHS and examples of good practice from elsewhere

Report Produced by: Lynne Selman, Independent Facilitator for the workshop. June 2009



Commissioning Transport for Health
Summary of workshop held 18th May 2009.

2.1 Objectives of the session:

- To identify and plan commissioning solutions to NHS-related transport issues for the local health economy over the next 1-3 years;
- To prepare for an up-coming multi-agency partnership meeting, to be led by KCC (Kent County Council). This will be planning for the next 3-5 years.

2.2 Presentations: (see copies of overheads – Appendix 3.2)

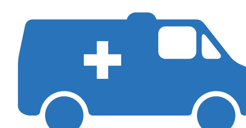
Those attending the workshop heard introductions and presentations from

- **Lynne Selman (facilitator) and Ann Sutton (PCT Chief Executive)** outlined why transport is important to the NHS and to the PCT specifically. This included reference to the importance of transport to achieving the PCT's overall aims of improving health outcomes and reducing health inequalities. It was a key issue raised by patients and public in terms of quality of experience in any public arenas visited by the PCT staff/Board and had a potential impact on hospital of "choice" via choose and book. Access problems were also known to lead to missed appointments – an inefficient use of resources. Ann re-iterated the importance of transport to our public, and drew attention to the KCC's regeneration strategy and it's recognition of transport as a key issue. She also thanked all those present and was pleased by the cross-sector representation attending.

- **Martyn Ayre, (KCC Senior Policy Manager).** Martyn emphasised the importance of inter-agency partnership working in the context of transport for healthcare. Accessibility of services was also a key feature for KCC when listening to local people/its councillor' concerns. The changing demographics in Kent required adaptation and change. Local Area Agreement targets included achieving access to hospitals within 30 mins by 2010/11;

- **Gillian Wells, East Kent Infrastructure Group & Sue Sawyer (voluntary & community sector)** Gillian also emphasised the importance of partnership working . As background, she gave statistics regarding the voluntary sector in the Eastern and Coastal Kent area and explained that of the 2400 voluntary organisations, about 25% were involved in health/healthy living work. Approximately 54% of journeys undertaken were health-related (117,000 journeys last year to appointments) and a further 46% related to healthier living/lifestyle initiatives. Quality was seen as important as cost and information about what is available is key. Sue Sawyer emphasised the importance of transport to carers/family as well as patients; continuity of service was also important to them. Parking as well as transport was a concern.

- **Jenny Knight, (Assistant Director, Public Engagement, NHS ECK)** reported on the work of the Integrated Transport Working Group. This group had been in place (initially to support the work of the Urgent Care programme) for about 2 years with inter-agency membership, including transport and



healthcare providers. They took on board issues raised by the public and others via PCT roadshows, for example. They had developed new, improved leaflets, a website, and regular articles/information space in "Health News". Key issues currently under consideration were transport to London hospitals and work on linking information to support patient choice/"Choose and Book";

- **Adrian Fox, (Dover District Council)**, explained his role as a policy planner in Dover District Council. He outlined a transport study undertaken in Dover in 2007 by an external consultant – copies available on the DDC website. The "Visim" model maps transport movement and gave DDC a baseline of data for use in decision-making in the area. It also incorporated a health equity audit. The model was used to support decision-making for the site of a new Dover Community hospital, measuring access to a number of potential sites by foot and by public transport. The study cost £320,000. Other local councils were exploring the use of something similar.

2.3 A short Q and A session took place to clarify/expand on the presentations:

- It was clarified that **voluntary car services** were not free and had criteria for access eg low income, disability or living in an area with little public transport; whilst they are not free, they are "not for profit", costing, typically, 40-45p per mile. Most people heard about the services by word of mouth, but it was clarified during the workshop that the Integrated Transport Working Group leaflets did give contact details for such voluntary sector services.

- Further information on the Local Area Agreement ("LAA") target of **accessing hospitals within 30 mins**. was given, confirming it was a 3 year target against a baseline determined last year. The definition of "hospital" was the 8 major hospital sites in Kent. For access to GP surgeries, the LAA target was 15 mins.

2.4 Group Work:

The first discussion was to capture key issues regarding transport for health care (each group was asked to discuss generally and then consider the needs of specific localities across Eastern and Coastal Kent.). The groups were then asked to identify 3 priority areas that *commissioners* should work on further, along with any ideas for improvements that healthcare *providers* could make.

[The discussions within the groups have been typed up as "flip charts" and attached at appendix 3.3].

2.5 Plenary discussion then followed to consider the priorities identified by each group and narrow these down to three topics that could be scoped out as projects to take forward.

The following are the priorities put forward by the three groups **(NB not in priority order)**:

Group 1:

1. Transport considerations should be featured in *all* commissioning plans;
2. There should be greater integration between transport planners and healthcare commissioners;
3. Services should be near the patient wherever possible/practical, making better use of local capacity and reducing the need to travel;

Group 2:

1. Parking – again taking the service to the patient/locally wherever possible to reduce travel (eg phlebotomy);
2. Incentivize those who can use public transport to do so. In particular staff – free up parking spaces for those who *must* drive/park;

3 Consider suitability/size of public transport especially in rural areas eg reduce size/increase frequency in rural areas;
4 Linking transport to more-personalised/individual care plans.

Group 3:

1 Requirement to have some form of needs assessment/baseline assessment/gap analysis as a basis for further work;
2 Need for better information (especially "real time" information) and linked to "choose and book" information to aid decision-making for the patient;
3 As sustainable travel plans are now a "must do" for NHS organisations – consider alternative off-campus/out of town parking (eg retail, leisure centres/park-and-ride) and shuttle services to main sites.

Attendees were then asked to "vote" for three of the above to work on in more-detail, scoping out 3 projects. Some aspects of discussion were linked together (eg incentivising staff to use public transport was linked to Group 3's 3rd point.)

The outcome of discussion for further work to be done was as follows:

- Undertaking a needs assessment/baseline assessment for transport to health services;
- Use of existing, available off-campus transport for patients, visitors and staff ;
- Developing a "toolkit" /checklist for transport in NHS commissioning plans.

2.6 Group Discussion on the 3 proposed projects to take forward:

Each of the three groups worked on one of the above topics and scoped out further work for the next 6 months-3 years. A summary of each of these is outlined as a flip chart in appendix 3.3B

2.7 Recommendations from the workshop.

It was proposed

a) that the three projects outlined in 2.5 above i.e.

- *Undertaking a needs assessment/baseline assessment for transport to health services;*
- *Use of existing, available off-campus transport for patients, visitors and staff ;*
- *Developing a "toolkit" /checklist for transport in NHS commissioning plans.*

be recommended for priority action to be led by the PCT (eg Transport Commissioner), in partnership with healthcare providers, the voluntary sector, transport providers, KCC and local councils, patients and the public. This report and its recommendations to be considered by the NHS Eastern and Coastal Kent Commissioning Strategy Group and built into future iterations of the Strategic Commissioning Plan.

b) the terms of reference of the existing East Kent Integrated Transport working group be reviewed to widen its' scope to include the Swale area, to act as a commissioning, rather than an implementation group, and widen its membership in order to give greater focus on the voluntary and community sector.

c) that there should be continuity between the work/attendees at this event and the planned KCC strategic event (date to be advised)

2.8 Concluding Remarks:

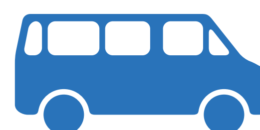
Ann Sutton closed the event , commenting on the complexity of the subject, the urgency for improvements and the challenges of increasing access at the same time as reducing the NHS carbon footprint. She was confident that the work would be taken forward, led by the PCT, but required real commitment from both NHS and other partner organisations to succeed.

2.9 Evaluation of the event:

A summary of comments/feedback on the usefulness, relevance and environment of the workshop is attached at appendix 3.4. The vast majority of those attending felt the workshop had made progress on this topic, and were confident that improvements would be achieved. Most felt the venue (Ashford International Hotel) was a good environment for the event, although several commented that it was not adjacent to a station/easy public transport access, which in terms of sustainability, should perhaps be a consideration for future events.

The NHS Carbon Reduction Strategy
"Saving Carbon, improving health":

Key areas for action include travel and transport: "Review and monitor all travel needs, incentivise low carbon travel, promote care closer to home and home working"



"Commissioning Transport for health"

Report of Workshop, held 18th May 2009

3. List of Appendices:

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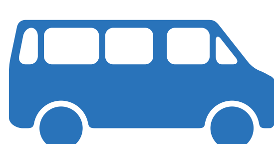
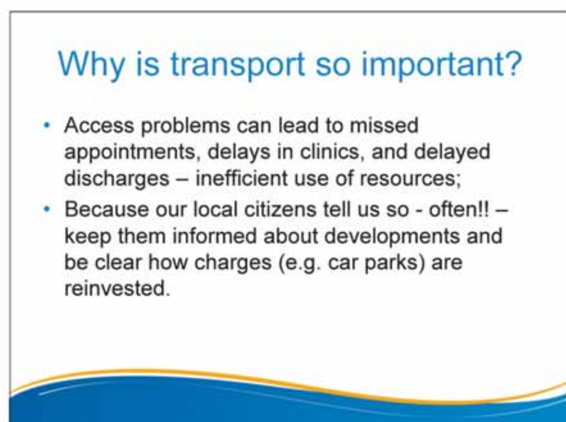
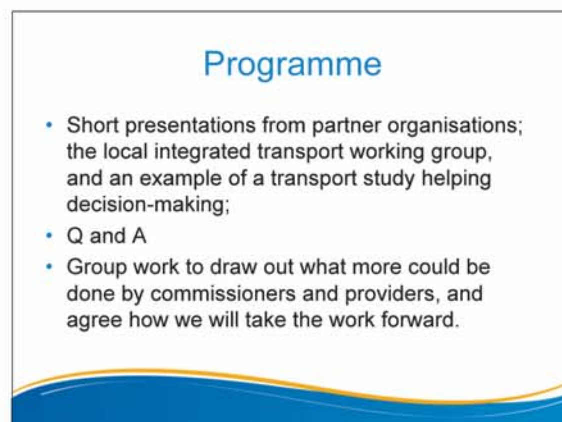


Appendix 3.1

Interagency Transport Meet - 18/05/09 Attendee list Appendix 3.1	
Name	**Organisation**
Ann Sutton	Eastern and Coastal Kent PCT
Jenny Knight	Eastern and Coastal Kent PCT
Andrew Coombe	Eastern and Coastal Kent PCT
David Muir	Eastern and Coastal Kent PCT
Ian Haylock	Eastern and Coastal Kent PCT
Robert Stewart	Eastern and Coastal Kent PCT
Elizabeth Insley	Eastern and Coastal Kent PCT
Caroline Davis	Eastern and Coastal Kent PCT
Andrew Cole	Eastern and Coastal Kent PCT
Lorraine Denoris	Eastern and Coastal Kent PCT
Anne Tidmarsh	Eastern and Coastal Kent PCT/Kent County Council
Ali O'Grady	Eastern and Coastal Kent PCT
Lynne Selman	External Facilitator
Martine McCahon	West Kent PCT
Tracey Fletcher	East Kent Hospitals University Foundation Trust
Angela Munden	GP Practice
Liz Cruize	GP Practice
Louise Pilcher	Practice Based Commisioning
Isabel Woodroffe	East and Coastal Kent Coastal Services
Chris Davies	East and Coastal Kent Coastal Services
Stephen Carey	Patient/Public Rep
Ann Murray	Patient/Public Rep
Gerald Harman	Patient/Public Rep
Martyn Ayre	Kent County Council
Tim Woolmer	Kent County Council
Kenneth Cobb	Kent County Council
Simon Allum	Kent Highway Services/KCC
Graham Tanner	Kent Highway Services/KCC
Jacqui Elliot	Kent Highway Services/KCC
Sally Benge	Kent Highway Services/KCC
Helen Medlock	South East Coast Specialist Commissioning
Adrian Fox	Dover District Council
Andy Cashman	South East Coast Ambulance Service
Ray Savage	South East Coast Ambulance Service
Graham Collins	South East Coast Ambulance Service
Sue Sawyer	Volunteer Centre representative
Gillian Wells	East Kent Infrastructure Group (Voluntary Sector)
Kevin Halpin	Kent and Medway Partnership Trust
John Carey	Kent and Medway Partnership Trust
Derek Bates	Kent and Medway Partnership Trust
David Tamsitt	Kent and Medway Partnership Trust

Appendix 3.2
Presentations





Breaking the cycle of health inequalities

Revolutionising services for older people

Tackling the 'key killers'
cardiovascular disease,
cancer and respiratory disease

Promoting well-being and good mental health

Transforming life chances for disadvantaged children

The Wider Picture…
Working in Partnership

Martyn Ayre
Senior Policy Manager
Corporate Policy

Our Aims…

- Accessibility of services
- Tailored to customers' needs
- Value for money
- Maintaining service excellence
- Innovation
- 'Seamless' Provision

Our Challenges…

- Declining government expenditure
- Economic downturn
- Changing demographics
- Changing expectations
- Shape of public services in future

Q: Can we turn these challenges into opportunities?

Vision For Kent / KA2

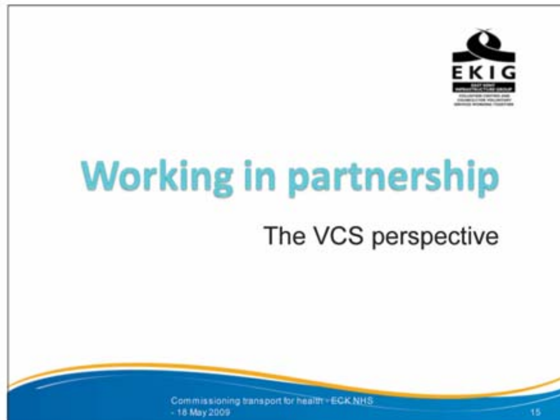
- Economic success
- Learning for all
- Improved Health, Care & Wellbeing
- Sustainable communities – urban and rural
- Quality of life
- Keeping Kent moving
- High quality, affordable homes

National Indicator 175 – KA2

- Improve access to healthcare by foot, bicycle or public transport
- Targets:
  - Access to hospitals within 30mins 2010/11 – 55.5% (increase of 1.5%)
  - Access to GP Surgeries within 30mins 2010/11 – 83.5% (increase of 1.5%)

National Indicator 175 – KA2

- Public Transport
  - Voluntary Schemes
  - Quality Bus Partnerships
- Location of new build developments
- Provision of services in community locations

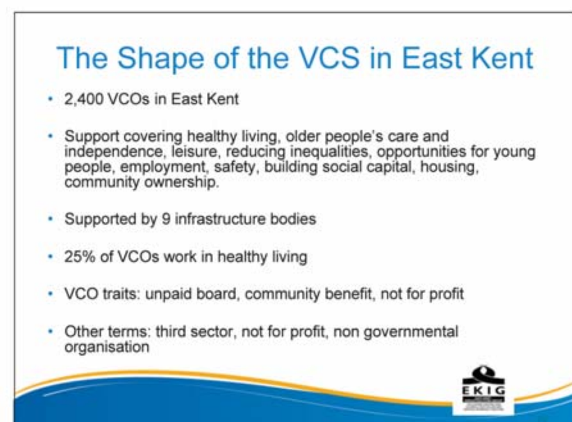

EKIG
Working in partnership
The VCS perspective
Commissioning transport for health - ECK NHS - 18 May 2009
15

Working in partnership
• Why partnerships?
• The role and development of the VCS in East Kent
• The VCS' role in transport provision
• Suggestions on smart commissioning to respond to future transport service needs in East Kent
EKIG

Why partnership in the VCS?
1. Playing to organisational strengths
2. Achieving critical mass
3. Geographical coverage
4. Strengthening providers
5. Economies of scale
6. Local delivery complemented with strategic planning
EKIG

Why cross sector partnership?
Achieving:
1. Well informed service provision in East Kent.
2. The ECK NHS objectives
3. World Class Commissioned services generally
4. Responding to greater needs for user centred transport provision
EKIG

Key elements of successful partnership working
• Buying in to a common aim: effective user centred transport for the public in East Kent that promotes healthy living;
• Understanding the context, opportunities and constraints of the other party;
• Working together to draw on mutual advantage, build opportunities and reduce constraints.
• Trust
EKIG


The Shape of the VCS in East Kent
• 2,400 VCOs in East Kent
• Support covering healthy living, older people's care and independence, leisure, reducing inequalities, opportunities for young people, employment, safety, building social capital, housing, community ownership.
• Supported by 9 infrastructure bodies
• 25% of VCOs work in healthy living
• VCO traits: unpaid board, community benefit, not for profit
• Other terms: third sector, not for profit, non governmental organisation
EKIG

Changes in the VCS

- More partnership working in order to work across East Kent (East Kent Infrastructure Group)
- Better knowledge of commissioning arrangements
- Moving towards partial social enterprise models
- Use of full cost recovery models
- Doubling in transport provision in 5 years

The Role of the VCS in transport

- 6 senior citizens forums covering East Kent actively researching need and inputting on transport .
- Volunteer centres provide tailored, not for profit, services to health appointments as well as other journeys that promote health and well being
- Age Concerns and other community centres provide a range of minibus transport

Volunteer Centre transport schemes

- Flexible and responsive service that builds in a waiting, care and befriending element for clients that adds value to the transport service;
- 54% of journeys health related, 46% of other journeys related to areas important to healthy, independent lifestyles
- Not for profit
- Cost effectiveness achieved through volunteer drivers.
- Highly regarded service

Volunteer Centre Transport in East Kent (2008/9)

Health related journeys	45,634	(39%)
Hospital visits	6,150	(5%)
Day centres	11,510	(10%)
Other journeys	33,059	(28%)
NHS contract journeys	7,312	(6%)
Other contracts	13,003	(11%)
Outside area	522	(1%)
Total	**117,190**	**(100%)**

Smarter commissioning – the process

- Involve VCS in service design – VC representation on the Integrated Transport Group
- Ensure provider development processes are undertaken in good time
- Reflect added value of tailored, user centered transport in any commissioned service
- Make quality criteria not just cost criteria important
- Build in enough tender time for partnership negotiation across East Kent;

Smart commissioning – the detail

- Set clear annual monitoring criteria at the outset;
- Pay costs monthly in arrears against actual trips invoiced
- Ensure contracts are three years or more with annual review
- Include transport that is not directly related to health visits but nevertheless supports healthy and independent lives
- Make sure all patients receive clear information about the rage of transport available

Volunteer Centre Transport in East Kent

Case Studies

Next stages

- Partnership working in identifying service need/service design
- Good VCS understanding of commissioning procedures and provider requirements
- Good partner understanding of VC transport work and its added value

NHS
Eastern and Coastal Kent

Adrian Fox
Principal Planning Officer
Dover District Council

Dover Transportation Study

- How did it come about?
- Who was involved in the Project? – DDC, KCC, HA, HCA, SEEDA, PCT, Dover Harbour Board, landowners, developers
- Started work in December 2006 and was substantially completed in December 2007

- Who was awarded the contract?
- How did we run the Project?
- What was involved? ATC, Roadside Interviews, Traffic counts, Camera counts & Existing data
- Developed a VISSUM Transport Model

- Transport Model signed off as being 'Fit for purpose' by both KCC and HA in record time!
- What does it do?
- How does it help us in the future?

- How did we shortlist the Dover Mid Town site?
- What did the Transportation Study and Accessibility mapping tell us?
- Mid Town came out as having the highest percentage of households in the District that could have access to the site within 30 minutes by foot and/or public transport

Conclusions

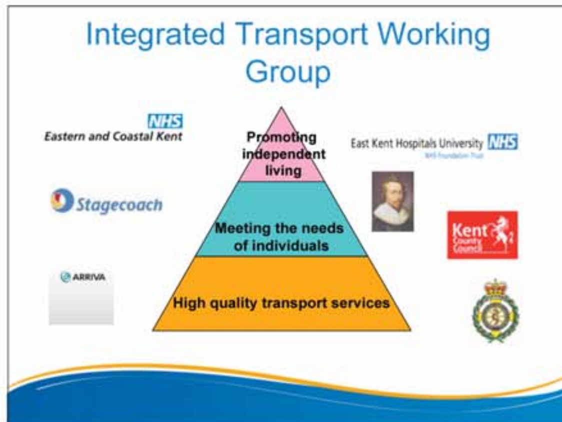
- Key requirement is that a Community Hospital should be easily accessible by foot and/or public transport
- All of the alternative sites were assessed against their access to deprived wards and access to public transport (health equity audit)

Conclusions

- Mid Town is located in the centre of Dover and the development of a Community Hospital will greatly assist with the regeneration of Dover and the Mid Town area
- Both the Dover Transportation Study and Accessibility Mapping are extremely useful tools that can assist with the decision making process

And Finally……

- What lessons have we learnt?
- What might we do differently in the future?



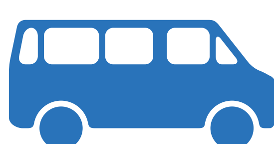
Key Objectives

- Implement effective commissioning models, maximising county and NHS resources
- Improve response to patient booking procedures
- Develop county-wide policies and efficient systems to monitor performance and budgetary control
- Greater use of sustainable transport
- Consulting with the residents of Kent, supporting an effective communication strategy
- To maximise potential funding streams and identify efficiencies for further integrated working

APPENDIX 3.3A

FLIP CHARTS FROM 3 DISCUSSION GROUPS

TOPIC:
"Key issues regarding transport for health care and three priority areas for further discussion"



APPENDIX 3.3A

FLIP CHARTS

SESSION 1

GROUP 1

FACILITATOR : MARTYN AYRE

1. GENERAL DISCUSSION:

- Medway PCT/Medway acute did not attend although invited, like W Kent & Maidstone Hospital Trust.
- Poorer people have higher levels of need
- West of Sittingbourne no transport to GP service. Taxi £10. attempted to run minibus but no help from PCT
- Proposals backed by patient group
- Problems getting to hospital at Medway Maritime.
- Voluntary services transport (eg Red Cross) does not have capacity in Swale and will not allow people to be accompanied;
- DNAs at hospital due to transport problems = wasted resources
- More community based/spec services and GPs as focus for elderly services good idea
- increase mobile services.

[NB it was noted that Swale Equitable access centre will address some of these issues]

2. PRIORITIES FOR FURTHER DISCUSSION IN PLENARY:

2.1 ensure transport is included in all commissioning plans;

2.2 ensure integrated working between transport planners and (NHS) commissioners

2.3 ensure greater emphasis on transport issues in primary care, not just acute/hospital services

APPENDIX 3.3 A

FLIP CHARTS

GROUP SESSION 1

GROUP 2

FACILITATOR: *ANDREW COLE*

1. INITIAL DISCUSSION

- *Any project groups should include older people + other disadvantaged people eg disabilities, mental health problems, mobility issues, low income etc.*
- *New/old build – assess public transport needs.*
- *Disabled parking – too few; park anywhere at no charge if disabled;*
- *Expanded facilities but no expanded parking*
- *Sustainable solutions*
- *Educate appropriateness of treatment centre*
- *Incentivise use of public transport for those that can*
- *Gov limitations on vol services*

2. KEY THEMES TO FEED BACK:

- *Take service to the patient;*
- *Incentivise those who can use public transport – education, including appropriate treatment*
- *Recruit to volunteer transport and other social forms of transport ie capacity building*
- *Marry flexibility and personalisation to the agenda*
- *Assess suitability of transport size to task/demand*

APPENDIX 3.3A

FLIP CHARTS

GROUP SESSION 1

GROUP 3

FACILITATOR : *LYNNE SELMAN*

1. KEY TRANSPORT ISSUES DISCUSSED:

- *Need more information about costs/routes for voluntary sector;*
- *Clearer information about eligibility criteria, especially for harder-to-reach groups;*
- *Make clearer info available on "Choice" menu*
- *Explore tension between "more" transport v need to reduce carbon/sustainable solutions; need to take account of workplace policies, patient transport and access for visitors*
- *Ensure service re-design incorporates related transport issues*
- *People don't expect free transport but do expect access to transport*
- *Make best use of existing transport - there are lost opportunities*
- *We need a "needs assessment" - Pensioners' forum doing a study, focussing on older people;*
- *Think about taking services to the individual rather than the reverse; use the voluntary sector to provide more services locally (eg social enterprise model)*
- *Affordability is a key issue*

2. GROUP'S PRIORITIES FOR FURTHER DEVELOPMENT (TO BE DEBATED/VOTED ON IN PLENARY SESSION):

Group 3's Priority One: Undertake full needs assessment (Commissioners) supported by existing providers (ie provision of information; performance information; prioritising the work and co-operation); This work would feed into the wider partnership working to be led by KCC

Group 3's Priority Two: Use of existing facilities for car parking, not used 24/7 which could support a more-convenient and sustainable model eg park and ride facilities/ leisure club facilities with shuttle service to hospitals/other main NHS facilities such as equitable access in primary care (action: commissioners); Providers to look at existing car parking facilities and provide information on costs/reinvestment of charges. Ensure all the above is linked to sustainable transport plans.

Group 3's Priority three: improve information to patients/clients. Expand the work already undertaken by Integrated Transport working group (eg website/leaflets); link to "choice".

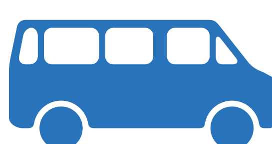
APPENDIX 3.3B

FLIP CHARTS FROM 3 DISCUSSION GROUPS (2)

TOPIC:
Scoping out the three most-popular projects, as voted on in the plenary session.

i.e.

- Undertaking a needs assessment on transport to healthcare;
- Use of existing and available, off-campus transport for patients, visitors and staff;
- Developing a "toolkit" to help commissioners include transport in all commissioning plans



APPENDIX 3.3B

FLIP CHARTS

SESSION 2

GROUP 1

FACILITATOR : MARTYN AYRE

PROJECT PROPOSAL: TRANSPORT COMMISSIONING TOOLKIT

Develop a "toolkit" to assist all commissioners to include transport arrangements in commissioning/de-commissioning services.

SUGGESTED LEAD/PROJECT SPONSOR:

PCT

OTHER KEY PLAYERS:

VCS; KCC; PBC; District/Borough Councils; patient groups

POTENTIAL FUNDING SOURCES:

PCT & KCC (in kind)

SUGGESTED PROJECT GOVERNANCE ARRANGEMENTS:

Integrated Transport Working Group to be project sponsor (whom does ITWG report to?)

SUGGESTED TIMESCALES:

Propose test out for developments in Swale as pilot; timescale to completion 6 months.

OTHER KEY POINTS MADE:

Suggested content of toolkit, to include:

- Standards;
- Provider development and support especially for vol sector.
- Clinical input to criteria setting essential
- Clear outcomes
- Checklist to be generic but allow for local variations
- Partner engagement link to clear strategy and plans;
- Transport planning skills required
- Knowledge of the market required (? training day)

APPENDIX 3.3 B

FLIP CHARTS

GROUP SESSION 2

GROUP 2

FACILITATOR: *ANDREW COLE*
(Dover/Thanet focus)

PROJECT PROPOSAL:

Transport needs assessment. Pilot in one area initially (suggest one of the more-deprived areas in Dover/Thanet).

SUGGESTED LEAD:

PCT (Transport Commissioner)

OTHER KEY PLAYERS:

- *Funding organisations*
- *Local government (all 3 tiers)*
- *Voluntary sector*
- *PCT/PBC Commissioners*
- *Patients and the public*
- *Providers of transport and services*

POTENTIAL FUNDING SOURCES:
PCT/SEEDA/KCC/GOSE/Private Sector (eg Pfizer)

SUGGESTED GOVERNANCE ARRANGEMENTS:

- *PCT transport lead/pilot study to define process*
- *Link to LSP's work*
- *Reporting lines for individuals to PCT, KCC, VCS, local government*
- *Potential for Integrated Transport working group to co-ordinate*

continued...

continued...

SUGGESTED TIMESCALES/INITIAL FEEDBACK:

Initial work:

- *Assess current plans and assets;*
- *Assess other national needs assessments undertaken eg Cornwall and Norfolk*

OTHER KEY POINTS MADE:

- *"Success will breed success"*
- *Link with LSP's*
- *There are a finite number of ways to access services;*
- *Personalised budgets and personalised approaches = organised market*
- *Local area agreement is a key driver for this*
- *Requires a strategy for user/PPE perspective to be produced and views integrated alongside those of commissioners*
- *Need to measure current usage levels*
- *Tricky to pool resources but logical to do so.*
- *"choose and book" has choice for first appointment but not for follow ups.*

APPENDIX 3.3B

FLIP CHARTS

GROUP SESSION 2

GROUP 3

FACILITATOR : *LYNNE SELMAN*

(Shepway/Canterbury/ashford focus)

PROJECT:

USE OF EXISTING PARKING FACILITIES TO INCREASE PARKING CAPACITY AND IMPROVE CARBON REDUCTION. 1ST PROJECT TO TAKE PLACE IN CANTERBURY LOCALITY eg use of non- NHS car parking capacity (Park and Ride/leisure/retail) and link to a shuttle service to key health facilities.

SCOPE OF PROJECT:

- *Establish a baseline, including review of travel plans from elsewhere - local, regional, national;*
- *Link to requirement to reduce carbon*
- *Look at the perspective of staff, visitors and patients;*
- *Ensure outcome is joined up between organisations and reflected in their sustainable transport plans (especially KCC, EKHT; Kent and Medway Partnership Trust and EKC PCT);*
- *Link to the work on needs assessment (separate project)*
- *Consider the real costs to the patient, commissioner, providers, and include "hidden" costs such as car parking*
- *Consider especially the needs of "harder to reach" groups of the population;*
- *Include information on services, including "real time" access to information*
- *Link to work on "personalised" care and health budgets*
- *Incorporate issues raised in another group regarding incentives/disincentives & the requirement to "personalise" services*

SUGGESTED LEAD:

A key PCT individual to be identified (eg existing or new project/commissioning post) to be given the work as a priority piece of work.

continued...

continued...

OTHER KEY PLAYERS:

- *Kent and Medway Partnership NHS Trust*
- *Voluntary sector (EK KIG?)*
- *KCC*
- *Canterbury City Council*
- *Ad hoc input from others eg HR; Bus operators;*

POTENTIAL FUNDING SOURCES>

A) PROJECT - PCT to lead and fund project costs;

B) IMPLEMENTATION: main funding issue required co-operation and participation from all parties, including time/staff resource

PROJECT GOVERNANCE ARRANGEMENTS & REPORTIING STRUCTURES:

- *Potential to expand scope of ITWG to take account of this issue (currently reports to Urgent Care Board)*
- *Initial report & progress reports to PCT Commissioning Strategy group - which includes practice-based commissioning reps*
- *Performance reports to PCT Integrated Governance Committee as part of routine performance reporting which will be required on carbon reduction (as now an NHS "must do"); similarly for all NHS bodies within their own structures.*

TIMESCALES

Identify initial goals and fully scope out project - 2 months from "go ahead"; initial feedback on progress 6 months; timescale for completion: 3 years, including proposals to widen out to other localities.

OTHER KEY POINTS DISCUSSED:

- *Refocus ITWG to become a commissioning, rather than provider-led group?*
- *Ensure that the focus is to reduce the overall/collective number of miles travelled as well as improving access to patients/visitors.*

APPENDIX 3.4

SUMMARY OF FEEDBACK

TOTAL RESPONSES: (33)

NB

- **some respondents ticked several statements;**
- **some respondents did not complete all statements.**

Outcome of evaluation is shown in ( )

Please indicate with a ✓ which of the following apply:

Q1. I found the session

a) useful **(19)**

b) interesting **(18)**

c) neither of the above **(1)**

Q2. The most useful part of the workshop for me was: (please ✓ all that apply)

a) the presentations	**(5)**
b) the discussion groups	**(20)**
c) networking	**(6)**
d) all of the above	**(9)**
e) other:	

Comments: "Feedback very useful"; "now know more about the complexities of the NHS/PCT process"

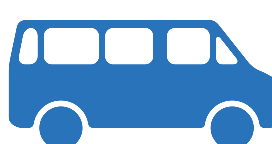
Q3. ***I am*** confident (27) ***/ am not confident*** (2) transport services will improve as a result of today's workshop ***(delete as applicable)***

Comments: (I need to know how the 3 priorities are to be progressed before commenting)

Q4. I feel the workshop gave a good foundation for the local NHS to go forward into the wider partnership arena, with some clear ideas on improvements

yes (31) /no (0)

continued...



continued...

Q5. Please add below any ideas you have as to how the content of the workshop could have been improved:

Comments (summarised) were as follows:

- Would have liked to see current services/situation/providers mapped out;
- Longer discussion sessions would have been helpful, but appreciate time constraints;
- successful in covering/achieving a great deal in a short time
- pinning individuals down as to how going forward
- clearer process ref voting options
- PBC, commissioning and patient attendance/representation should have been greater
- Excellent facilitation
- Emphasis was on secondary/acute care; more attention on primary care would have been helpful; but it was good opportunity to put across Swale needs.

Comments on taking work forward in the future

- Include voluntary sector in the Integrated Transport working group in future
- All transport arrangements in future must be linked to carbon reduction and sustainability; should be used as basis for future planning.
- Personalisation – use of Kent Card or KASS id and market development
- West Kent PCT representative – felt helpful to scope out their own work.

Q6. Venue/Catering:

The venue was poor/adequate/***good (17) excellent (10)***

The catering was poor/adequate/***good (17) /excellent (8)***

Please add any additional comments you may have on venue/catering

Summary of comments recieved:

- Venue not easy to access without car/not a "sustainable" location (several comments received)
- More space to enable everyone to feel part of the group*
- Room too hot
- 9am start too early – not good for childcare/school run;
- Lack of cold water; no fruit juice as alternative to tea/coffee;
- Ran out of coffee on arrival*

**** NB more participants attended than had responded to the invitation!!***

APPENDIX 3.5

Handout at workshop – Transport access to NHS facilities:

1. According to recent studies*…

- 31% of people without a car have difficulties travelling to local hospital
- 17% of people with a car have difficulties travelling to local hospital
- Nationally 1.4m people have missed, turned down or not sought medical help in last 12 months because of transport problems;
- DH Guidance states NHS bodies should have arrangements for free or concessionary parking (well advertised) for patients /primary visitors using facilities frequently;
- In National Patient Choice Survey Sept 08 – "location/transport/easy to get to" was listed by over 50% of respondants – more than "reputation of consultant" as a factor in choosing a hospital.

2. Some good practice examples:

- Working with local council – bus service from "park and ride" to hospital sites at regular intervals (15 mins) (Oxford)
- NHS commissioned and managed bus service; improved cycle facilities and car-share for staff (Cambridge)
- Range of measures introduced to reduce car use by staff and ensure patients/visitors do not have to search longer than 10mins for a space (eg increased number of direct bus routes (doubled); reducing staff parking spaces by 10%) – (Plymouth)
- Planning new health and social care facilities (co-located with GP surgeries/multi-purpose clinics) to reduce the need for travel/close to population centre. (Leicester)and "Darzi" equitable access.

3. How do we promote local improvements and good practice in the national arena & to patient and the public? eg outcome/success of local work …

- William Harvey travel plan/showers for staff to encourage cycling;
- "pyjama run" – out of hours transport - urgent care programme;
- Medway FT – survey of FT Members ref transport

* Source: NHS Confederation 2009

Eastern and Coastal Kent

"Commissioning transport for Health"

Report of workshop held 18th May 2009
Ashford International Hotel, Ashford, Kent.

Available in large print on request
or other formats by ringing
01233 618382 or via email to
alison.o'grady@eastcoastkent.nhs.uk

Report compiled by
Lynne Selman
Tel: 07768 2977709
Email: bjselman@btinternet.com

Design by
Emia Creative Design
www.emiadesign.co.uk
07801 313050

June 2009