THE BEST CONFIGURATION OF HOSPITAL SERVICES FOR WALES:
A REVIEW OF THE EVIDENCE

ACCESS

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1 INTRODUCTION

Over the life of the NHS, primary, community and hospital services have been subject to continued reorganisation and rationalisation. Often changes reflect developments in medical practice – for example advances in medicine and surgery have driven clinical staff and equipment to become more specialised and have decreased our reliance on bed rest as part of treatment. At the same time, there continues to be strong political and policy pressures to sustain and where possible increase local access to services, particularly those needed in an emergency such as Accident and Emergency services and maternity services.

This paper provides a summary of the evidence currently available in relation to access to healthcare services in the context of hospital care. It aims to inform and support the national and local discussions on the case for change in Wales.

2 EXECUTIVE SUMMARY

Access to healthcare services is complex and comprises a number of key elements:

Figure 1: Key elements of access to healthcare

In considering access in the context of service change it is therefore important to look at the factors impacting on access, not just geographic access.

There are important social and quality reasons to ensure good access to services, both in terms of geographic access and timely access. Increasingly therefore it is necessary to look at pathways of care, with only specialist elements having to be delivered further away, with as much care being provided locally as possible. It is recognised that the role of new technologies to support this will be important.
Work undertaken in Wales through Citizen’s Juries and Focus Groups suggests that when given the facts and options people are prepared to travel further to receive a safer, higher quality services where there is clear evidence to support this, particularly for life threatening conditions and treatments such as cancer and major trauma.

3 CONTEXT

3.1 Policy Context

The Welsh Government has devolved responsibility for the NHS in Wales and is responsible for setting the policy framework within which the NHS operates. There are a number of key policy documents that will need to be considered in the context of any case for change developed at a National or local level. Some of the key policy documents are identified below.

3.1.1 Together for Health

Together for Health sets out the five year vision for the NHS in Wales (Welsh Government, 2011). While recognising that good health will require action on many fronts, not just the traditional health sector, it focuses on the need to create a modern NHS capable of delivering high quality care at a time when it faces some of its’ toughest ever challenges.

Together for Health identifies a number of factors driving the need for reform:

- A rising elderly population
- Enduring inequalities in health
- Increasing numbers of patients with chronic conditions
- Changes in clinical practice, with some areas facing serious difficulties in recruiting specialist staff
- Poor performance, lagging behind similar countries in some important aspects
- A challenging financial climate

The document sets out how the NHS will look in five years time, with primary and community services at the centre of delivery.

The main commitments in Together for Health are:

- Tackling poor health, particularly among the most disadvantaged communities
- Creating one system for health, building on the establishment of integrated NHS organisations working with local partners
- The developing of delivery plans for major services such as cancer, cardiac care, stroke care and mental health
- Developing hospital services fit for the 21st century, working as part of a well designed, fully integrated network of care, with strengthened primary and community services
- Aiming at excellence everywhere, with effective quality assurance arrangements in place
• Transparency on performance, with improved information available for the public
• A new partnership with the people of Wales
• The development of a new financial regime that will improve planning and utilization of resources, and increase clinical involvement in decision making.
• The development of a strategic workforce and organization development framework.

3.1.2 Setting the Direction – Primary & Community Services Strategic Delivery Programme

*Setting the Direction* (Welsh Government, 2010) sets out the Welsh Government’s framework to strengthen primary and community services. It seeks to build on strengths within the current system, whilst at the same time directly tackling some of the existing challenges. The key purpose of the document is to set out a framework aimed at assisting Local Health Boards in Wales in the development and delivery of improved primary care and community based services for their local populations; particularly for those individuals who are frail, vulnerable and who have complex care needs. The key underlying Principles for improvement include:

• Universal population registration and open access to effectively organised services within the community
• First contact with generalist physicians that deal with undifferentiated problems supported by an integrated community team
• Localised primary care team-working serving discrete populations
• Focus on prevention, early intervention and improving public health not just treatment
• Co-ordinated care where generalists work closely with specialists and wider support in the community to prevent ill-health, reduce dependency and effectively treat illness
• A highly skilled and integrated workforce
• Health and social care working together across the entire patient journey ensuring that services are accessible and easily navigated
• Robust information and communication systems to support effective decision-making and public engagement
• Active involvement of citizens and their carers in decisions about their care and well-being.

The proposed system of care aims to deliver an easily recognisable, highly organised model of integrated community services that will act as a bridge between primary care and the acute hospital. Services will be focused on the holistic needs of the citizen and delivered by the NHS, Local Authorities and other partner agencies working together.

The approach advocates a change from reactive crisis management to a proactive, coordinated and preventative agenda, with a particular focus on high risk patient groups and those with increasing frailty. Such services will enable an increasing number of people to be managed effectively in their communities and localities, avoiding unnecessary and often debilitating hospital admissions.

This system would replace the current “push” hospital-discharge model with one that actively pulls patients towards high quality organised services closer to home.

This will be dependent on flexible working across professions and organisations to ensure that skills are utilised to maximum effect and that services meet the need of the citizen.
3.1.3 Rural Health Plan for Wales

The Welsh Government’s Rural Health Plan (Welsh Government, 2010) has been developed to ensure that the health needs of rural communities are met in a way which reflects the particular conditions and characteristics of rural Wales. It identifies three key themes: access to services; service integration, with particular reference to workforce; community cohesion and engagement. Of particular relevance to quality and safety, the Rural Health Plan recognises that some rural areas indicated difficulties in attracting and retaining appropriately trained staff at all levels and across both health and social care and that this was impacting on the ability to sustain safe, high quality services. It recognises the need to take account of, and balance, four competing factors when planning services, concluding that an emphasis on accessibility of services can adversely affect their quality while totemistic adherence to critical mass was not justified.

Figure 2: Competing factors when planning services

3.1.4 Welsh Health Standards

Doing Well, Doing Better – Standards for Health Services in Wales set out the requirements of what is expected of all health services in all settings in Wales (Welsh Assembly Government, 2010). There are a number specifically relevant to access:

Box 1: Doing Well, Doing Better – Standards for Health Services in Wales, Welsh Assembly Government 2010

Standard 2: Organisations and services have equality priorities in accordance with legislation

Standard 7: Organisations and services will ensure that patients and service users are provided with safe, effective treatment and care

Standard 12: Organisations and services comply with legislation and guidance to provide environments that are accessible

3.1.5 Wales Spatial Plan

The Wales Spatial Plan – People, Places, Futures – was originally adopted by the National Assembly for Wales in November 2004. This Updated document gives status to the Area work which has developed since 2004.
The broad 20 year agenda and overall role, purpose and principles of the Wales Spatial Plan remain unchanged:

- Making sure that decisions are taken with regard to their impact beyond the immediate sectoral or administrative boundaries and that the core values of sustainable development govern everything we do.
- Setting the context for local and community planning.
- Influencing where money is spent by the Welsh Assembly Government through an understanding of the roles of and interactions between places.
- Providing a clear evidence base for the public, private and third sectors to develop policy and action.

It is a principle of the Wales Spatial Plan that development should be sustainable. Sustainable development is about improving wellbeing and quality of life by integrating social, economic and environmental objectives in the context of more efficient use of natural resources.

The Wales Spatial Plan aims to deliver sustainable development through its Area Strategies in the context of the Welsh Assembly Government’s statutory Sustainable Development Scheme.

It sets out cross-cutting national spatial priorities. These provide the context for the application of national and regional policies for specific sectors, such as health, education, housing and the economy, reflecting the distinctive characteristics of different sub-regions of Wales and their cross-border relationships.

It identifies six sub-regions in Wales without defining hard boundaries, reflecting the different linkages involved in daily activities. In each of these Areas, local authorities, the private and third sectors, and the Welsh Assembly Government and its agencies are working together in Spatial Plan Area Groups to achieve the strategic vision for that area.

These agreed visions and the actions required to achieve them set an important regional context, both for citizen-centred service delivery and land use. They inform, and will be informed by, community strategies, local development plans and the work of the Local Service Boards.

The Wales Spatial Plan aims to deliver sustainable development through its Area Strategies in the context of the Welsh Assembly Government’s statutory Sustainable Development Scheme. It sets out cross-cutting national spatial priorities. These provide the context for the application of national and regional policies for specific sectors, such as health, education, housing and the economy, reflecting the distinctive characteristics of different sub-regions of Wales and their cross-border relationships. These agreed visions and the actions required to achieve them set an important regional context for the development of transport plans.
3.2 What Do We Mean by Access?

Welsh Health Standards define access as “the extent to which people are able to receive the information, services or care they need”.

Despite frequent references to, and common rhetoric around “equitable access to health care” research has confirmed that little agreement has been reached on the specific meaning of this notion, and the absence of a commonly accepted, specific definition of “equitable access” can therefore be problematic as there is no reference point to judge the consistency of health care policies.

Access to Health Care – Report of a Scoping Exercise (Guilliford, 2001) suggests that facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health. It suggests that access is therefore not simply about having and gaining access, but also about the ability to benefit from access, setting out four aspects of access:

- If services are available, in terms of an adequate supply of services, then a population may have access to services.
- The extent to which a population gains access will depend on the financial, organisational and social/cultural barriers that limit the utilisation of services. Thus utilisation is dependent on the affordability, accessibility and acceptability of services and not simply adequacy of supply.
- Services available must be relevant and effective if the population is to gain access to satisfactory health outcomes.
- The availability of services, and barriers to access, have to be considered in the context of the acceptability to the population, recognising differing perspectives, health needs and cultural settings of diverse groups in society. Facilitating access is then concerned with helping people to command appropriate health care resources in order to preserve or improve their health.

Figure 3: Access to Health Care

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1 Oliver et al, (2004) Equity of access to health care: outlining the foundations for action; J Epidemiol Community Health 2004;58:655-658
Access can also be considered in the context of other evaluative criteria as summarised below:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td>• Equity will be achieved when services are equally accessible to all with equal need</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>• Effectiveness, at the community level, will be maximised when services are accessed by all those with the capacity to benefit</td>
</tr>
<tr>
<td>Efficiency</td>
<td>• Efficiency may be compromised when services are made easily accessible to those with little capacity to benefit</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>• Services will be delivered appropriately when access is matched with individual and population need</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>• Services will be delivered appropriately when access is matched with individual and population need</td>
</tr>
</tbody>
</table>

(Source: Guilliford, 2001)

It is clear that access to health care services is not a simple concept. In considering the need for service change, the implications for access on local populations must be considered in its broadest sense.

4 ACCESS – WHAT DOES THE EVIDENCE TELL US?

4.1 Factors Influencing Access

4.1.1 Patients’ Help-Seeking Behaviours

There is evidence of a significant mismatch between professional expectations, patients’ needs and patterns of uptake of services. This is exemplified by the low uptake of preventive services by some groups\(^2\), the delays in accessing care for serious conditions\(^3, 4, 5\), or over-utilisation of emergency services for what is deemed medical ‘trivia’\(^6\). There are particular problems in gaining access to health care for marginalised groups, including homeless people, new immigrant groups and institutionalised populations.

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\(^2\) Cancer Research Centre 1997. Cancer Fact Sheet No. 7.5
4.1.2 Financial Barriers

Financial factors may encourage or inhibit patients’ use of services, and may also encourage or discourage the provision of services. There is evidence to show that prescription charges are negatively associated with the uptake of prescription medicines\(^7\), but there is little evidence for effects of user charges on access to primary care services more generally.

There is evidence that the indirect costs of utilising health care may act as a barrier to access, especially for more deprived groups and in rural areas. As NHS hospital care is free at the point of delivery, there is little evidence from the UK on the impact of different reimbursement methods on provision and utilisation of hospital services.

4.1.3 Availability of Services

Problems of access in relation to the location and configuration of services have been the subject of much work, especially in rural areas. In general, the distance from a service is inversely associated with utilisation, especially for specialist services. The research suggests that travel time, costs and availability of reliable transport are often more important than physical distance per se.\(^8\),\(^9\).

While historically service change has not benefited from research evidence on the effectiveness, efficiency or equity of different approaches\(^10\) new approaches to assessing the impact on access and equity are now being promoted, including the use of equality impact assessments and travel and access mapping tools. In guidance issued by the National Institute for Clinical Excellence\(^11\) the lessons to emerge included the need for:

- Coordinated local research to understand the transport access needs of key groups
- A focus on reducing the need to travel (especially by car) to NHS sites
- Effective local transport and health partnerships with senior backing
- Joint commissioning of transport services to the NHS
- Development of local indicators and targets to track improvements in access to services for key groups or areas

4.1.4 Organisational Barriers to Access

Organisational barriers are important in determining the timeliness and acceptability of care. At primary care level barriers may include the ability to register with GPs, obtaining a timely appointment, or accessing advice out of normal working hours. For hospital services, the main barrier has often been perceived as waiting lists and waiting times for elective hospital care. Evidence, however, suggests that for many people, being seen quickly is not always the most important consideration – being able to obtain an appointment on a day of choice and seeing a particular health professional are also important for some

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\(^8\) Goddard & Smith (1998). Equity of Access to Health Care York: *University of York*


\(^10\) Sheldon (2001). It aint what you do but the way that you do it *Journal of Health Services Research Policy* 6: 3-5

\(^11\) NICE (2008). Accessibility planning and the NHS: improving patient access to health services
patient groups\textsuperscript{12}. Commentators have concluded that, in general organisational barriers result from lack of capacity and/or inefficient use of existing capacity.

4.1.5 Socio-Economic Factors

It is well known that there are substantial inequalities in health and health care utilisation across the UK including Wales, with evidence of inequity in access in relation to place of residence, socio-economic status, ethnic group, age and gender.

A consistent theme emerging from the literature is the importance of working to ensure that health care resources are mobilised to meet the needs of different groups in the population. Thus equity is a key indicator of ‘access’, whether access is measured in terms of health service availability, health service utilisation, or health care outcomes.

The Social Exclusion Unit report \textit{Transport and Social Exclusion: Making the Connections} (2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found that people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.\textsuperscript{13}

4.2 What Do Patients Tell Us About Access to Healthcare?

The Picker Institute has undertaken extensive patient surveys across the UK and reviewed the international literature. It has concluded that there are eight key aspects of healthcare that patients consider most important, and these are summarized below (Picker Institute, 2006):

\textit{Figure 5: Eight key aspects of healthcare that patients consider most important}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure5}
\caption{Eight key aspects of healthcare that patients consider most important}
\end{figure}

\textsuperscript{12} Salisbury et al (2007). \textit{An Evaluation of Advanced Access in Primary Care Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D}

\textsuperscript{13} Social Exclusion Unit (2003). \textit{Transport and Social Exclusion: Making the Connections}
Of note, the survey undertaken by the Picker Institute found that patients placed a high priority on communication, patient-professional interactions and treating patients as individuals. Patients rated issues such as choice of hospital or admission dates among the least important aspects of care.

The Picker Institute has also undertaken research into the issues of choice and have found that patient experience surveys in the UK and other developed countries demonstrates that having a say in the choice of care and treatment is a very high priority for patients\(^{14}\). It has highlighted that patients and “the public” are likely to say different things – and contend that to improve the effective delivery of healthcare by professionals, the evidence from patient experience is more significant and valuable. Their work has concluded that the focus of choice should be on what matters most to patient – choice of care and treatment options, through a process of shared decision making such that individual patients are helped to:

- Become well informed about their condition
- Understand the likely benefits and harms of the treatment options
- Communicate and apply their own values and preferences
- Share the decision and responsibility for it.

Work undertaken by The Health Foundation has also explored patient and public experience in the NHS as part of its Quest for Quality and Improved Performance (QQUIP) work\(^{15}\). The distillation of data from multiple sources found that patients and the public prioritise:

- Information and involvement in decision-making about care
- Being treated as an individual
- Choice where it makes a difference
- Predictable and convenient access
- Equitable treatment and health outcomes
- Being safe and protected from harm in healthcare settings.

A British Medical Association Survey in 2005 asked members of the public to rate ten options for increased government NHS funding, and the ranking was as follows: \(^{16}\):

1. Cleaner hospitals
2. Improved Accident and Emergency
3. Shorter waits for outpatient appointments
4. Research into new treatments

\(^{14}\) Picker Institute Policy Position No.4 Extending Choice – what matters to patients?
\(^{15}\) Leatherman & Sutherland (2007) Patient and Public Experience in the NHS – A Quality Chartbook. The Health Foundation
\(^{16}\) British Medical Association (2005). ‘Cleaner hospitals – more important to patients than choice’.
5. More funds for prevention
6. Better out of hours care
7. Expanded family doctor services
8. More time with doctor
9. Better hospital food
10. Choice of where to have an operation

Of note, however, National Patient Surveys undertaken by the Department of Health have found that geographical convenience and transport is ranked the highest priority by far (64% patients ranked this as the most important factor in the 2007 survey\textsuperscript{17}).

The Welsh NHS Confederation, which represents the seven Health Boards and three NHS Trust in Wales commissioned an online survey conducted by YouGov in 2011. 1004 adults completed the survey which, sought to establish the level of awareness about the management of the NHS in Wales, perceptions of quality and views on areas of policy, including the future for hospital services. Some of the key findings are summarized in the table below, by region where available\textsuperscript{18}: Overall attitudes were found to be very positive towards the NHS. The survey also found that people in Wales say they don’t mind travelling for specialist services if it means the care will be of higher quality, although there is no definition of what a specialist service is and, overall attitudes to concentrating services in fewer, larger hospitals are negative with most people opposing this, and believing their local hospital should provide every type of service.

\textsuperscript{17} Department of Health (2007) National Patient Choice Survey
\textsuperscript{18} Welsh NHS Confederation Survey Results 2011 http://www.welshconfed.org/Survey2011.htm
Table 1: Survey to establish the level of awareness about the management of the NHS in Wales, perceptions of quality and views on areas of policy, including the future for hospital services.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Response</th>
<th>Total</th>
<th>Mid &amp; West Wales</th>
<th>North Wales</th>
<th>South West Central</th>
<th>South Wales East</th>
<th>South West Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well informed do you feel about health services offered in your area</td>
<td>Well Informed</td>
<td>54</td>
<td>58</td>
<td>61</td>
<td>51</td>
<td>53</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Not Well informed</td>
<td>38</td>
<td>39</td>
<td>27</td>
<td>41</td>
<td>42</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>8</td>
<td>4</td>
<td>12</td>
<td>8</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Thinking about your most recent experience of the NHS in Wales, how would you rate your experience overall</td>
<td>Positive</td>
<td>691</td>
<td>62</td>
<td>65</td>
<td>65</td>
<td>54</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>16</td>
<td>20</td>
<td>5</td>
<td>13</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Don’t Know/Not Applicable</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>To what extent do you support or oppose the policy to concentrate services in fewer, larger hospitals</td>
<td>Support</td>
<td>27</td>
<td>20</td>
<td>22</td>
<td>32</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Oppose</td>
<td>59</td>
<td>73</td>
<td>57</td>
<td>52</td>
<td>58</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Don’t Know</td>
<td>14</td>
<td>7</td>
<td>21</td>
<td>16</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>I want access to access specialist health services at my local general hospital even if the care there isn’t as good as somewhere further away</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>21</td>
<td>18</td>
<td>20</td>
<td>23</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Oppose</td>
<td>61</td>
<td>61</td>
<td>61</td>
<td>64</td>
<td>60</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Don’t Know</td>
<td>14</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>More can be done to care for people at home and prevent them from having to go to hospital in the first pace</td>
<td>Agree</td>
<td>75</td>
<td>72</td>
<td>71</td>
<td>74</td>
<td>76</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>7</td>
<td>13</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>The NHS can improve the quality of care and save money by centralizing services</td>
<td>Agree</td>
<td>37</td>
<td>29</td>
<td>37</td>
<td>41</td>
<td>34</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>24</td>
<td>36</td>
<td>26</td>
<td>22</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>8</td>
<td>4</td>
<td>6</td>
<td>12</td>
<td>10</td>
<td>6</td>
</tr>
</tbody>
</table>

(Source: NHS Wales Confederation Survey Results)
In summary, the findings of the Picker Institute, Health Foundation and National surveys are consistent with the increasing evidence base that, when given the facts, patients and carers will prioritise excellence and quality over convenience when it comes to their health care treatment, particularly for major treatment interventions and life threatening conditions e.g. cancer treatment and stroke care.\(^{19}\)

### 4.3 Access (Travel Times) and Outcomes

There is limited general literature to enable an assessment of the impact of travel times on outcomes in healthcare services at a population level. There have, however, been a number of studies undertaken exploring the issues of access in terms of travel times in relation to outcomes for specific conditions. Some examples are given below:

**Table 2: Examples of studies undertaken exploring the issues of access in terms of travel times in relation to outcomes for specific conditions.**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jones et al (2008) <em>Travel times to healthcare and survival from cancers in Northern England</em> European Journal of Cancer Volume 44 Issue 2</td>
<td>The aim was to assess the effect of geographical accessibility on the stage of cancer at diagnosis and survival. After adjusting for age, sex, whether the first hospital visited was a cancer centre and deprivation of area of residence, late stage at diagnosis was associated with increasing travel time to GP for breast and colorectal cancers and risk of death was associated with travel time to GP for prostate cancer. Travel times to hospital and other accessibility measures showed no consistent associations with stage at diagnosis or survival, so travel to GP was the only influential factor.</td>
</tr>
<tr>
<td>Ravelli A et al <em>Travel time from home to hospital and adverse perinatal outcomes in women at term in the Netherlands.</em> BJOG 2010; DOI: 10.1111/j.1471-0528.2010.02816.x</td>
<td>A travel time from home to hospital of 20 minutes or more by car is associated with an increased risk of mortality and adverse outcomes at term in the Netherlands.</td>
</tr>
<tr>
<td>Nicholl, J et al (2007) <em>The relationship between distance to hospital and patient mortality in emergencies: an observational study.</em> Emerg Med J 2007;24:665-668</td>
<td>Increased journey distance to hospital appears to be associated with increased risk of mortality. Our data suggest that a 10-km increase in straight-line distance is associated with around a 1% absolute increase in mortality. The results showed a sharp increase in mortality for patients with respiratory problems, but less change in those with chest pain.</td>
</tr>
<tr>
<td>Souza VC, Strachan DP; <em>Relationship between travel time to the nearest hospital and survival from ruptured aortic aneurysm: record linkage study.</em> J Public Health 2995; 27:165-70</td>
<td>Failed to show any relationship between time to hospital and mortality.</td>
</tr>
</tbody>
</table>

For people with life threatening conditions, there is evidence that delay can be linked to poor outcomes, noting that it is the timing of the start of appropriate treatment rather than time of arrival at a hospital that affects outcomes. The scope for interventions to be provided by paramedics and/or rapid access to the specialist team once at the hospital may therefore offset or overcome the increased risk created by the additional travel time.

4.4 Access to Health Care in Rural Areas

The unique nature of Wales, with significant rural areas poses specific challenges for the delivery of health care in Wales and this is reflected in the Rural Health Strategy.

**Box 2: Access to Health Care in Rural Areas**

Key Findings of the Institute of Rural Health review of Wales (Institute of Rural Health, 2009)

- A minority of people in rural Wales have difficulty in accessing the following services: getting to dentists (18%), cinemas (18%), hospitals (13%), police stations (12%) and leisure centres (10%).
- The main problem lies in transport where 11% of households in rural Wales do not own or have the use of a motor vehicle. Over twice the proportion of those without a car have difficulties getting to a hospital than those with private transport.
- Access to primary health care in rural areas is complex - access is more difficult for people living in hamlets, villages and open countryside than for those living in rural towns, the longer the distance to a GP the poorer the prognosis and survival rates in certain cancers.
- Distance to specialist health services has been shown to decrease survival rates from some cancers and asthma. Travel time to specialist services can be costly in terms of time, energy, finance and emotions.
- Rural residents may not be as assertive when using out-of-hours services as their urban counterparts, thus leaving them vulnerable when urgent help is required. There is a need in rural areas for out-of-hours nursing and support care for people with chronic and terminally ill conditions.

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15 | The Best Configuration of Hospital Services for Wales: A Review of the Evidence • Access
The Royal College of Physicians Scotland (Weller, 2005) concluded that access to services in rural communities cannot develop without appropriate education, training and incentives. It suggested admission procedures to medical schools need to be cognizant of the fact that students drawn from rural areas are more likely to return to those communities and that undergraduate medical education needs to provide adequate exposure to rural health. Specialist training programmes have been developed in some countries, such as Australia to accommodate the specific training needs for rural practice recognising that GPs practicing outside of urban areas require different sets of skills.

5 Strategies to Reduce the Impact of Travel Times to Hospital

5.1.1 Reducing Demand

There has been extensive research to evaluate the scope to reduce demand on hospital services – both in relation to emergency and elective admissions.

In relation to major trauma there is evidence, reviewed by the Cochrane Collaboration for the effectiveness of public health interventions, to suggest that interventions can prevent injuries on the road, in the workplace and at home. This would suggest that any plans to review the provision of major trauma care should take account of the balance between public health and healthcare investment.

The case for change in relation to the care of acutely ill patients often focuses on the scope to reduce the number of unplanned admissions, particularly among those with exacerbations of chronic conditions, and to reduce length of stay through the provision of care closer to home. The Royal College of Physicians has recognised the need for appropriate care in appropriate settings, and has welcomed the opportunity to offer care in community settings where possible, while also emphasising the need for patients to have access to care in acute hospital settings and appropriate assessment and treatment when necessary. As a result there has been a considerable focus on the scope to reduce emergency admission to hospital, with particular focus on the role of primary care and community based services. The evidence would suggest, however, that despite considerable efforts to reduce emergency admissions the impact has been minimal to date (Gillam, 2010).

To better understand this, the Kings Fund undertook a study to assess the effectiveness of interventions aimed at reducing avoidable emergency admissions (Purdy, 2010) and the findings are summarised below.

Table 3: Summary of findings on study to assess the effectiveness of interventions aimed at reducing avoidable emergency admissions

<table>
<thead>
<tr>
<th>Evidence of positive effect</th>
<th>Interventions with evidence of little or no beneficial effect</th>
<th>Interventions for which further evidence is needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>reducing admissions</td>
<td></td>
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<tr>
<td>- Continuity of care with a GP</td>
<td>- Pharmacist home-based medication review</td>
<td>- Increasing GP practice size</td>
</tr>
<tr>
<td>- Hospital at home as an alternative to admission</td>
<td>- Intermediate care</td>
<td>- Changing out-of-hours primary care arrangements</td>
</tr>
<tr>
<td>- Assertive case management in mental health</td>
<td>- Community-based case management (generic conditions)</td>
<td>- Chronic care management in primary care</td>
</tr>
<tr>
<td>- Self-management</td>
<td>- Early discharge to hospital</td>
<td>- Telemedicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- cost-effectiveness of GPs in</td>
</tr>
</tbody>
</table>
- Early senior review in A&E
- Multidisciplinary interventions and telemonitoring in heart failure
- Integration of primary and secondary care

Reduction in Readmissions
- Structured discharge planning
- Personalised health care programmes at home on readmissions
- Nurse-led interventions pre- and post-discharge for patients with chronic obstructive pulmonary disease

A&E
- Access to social care in A&E
- Hospital-based case management
- Rehabilitation programmes
- Rapid response teams

5.1.2 Use of Technology

While there is little evaluated evidence associated with the use of new technologies to support the delivery of health care services, there is a general acceptance technology can be used in a number of important ways to support care closer to people’s homes.

Figure 7: Technology being used to support care closer to people’s homes

Black et al undertook a systematic review of the systematic reviews assessing the effectiveness and consequences of various eHealth technologies on the quality and safety of care (Black, 2011). The study divided eHealth technologies into three main categories: (1) storing and managing and transmission of data (2) clinical decision support; and (3) facilitating care from a distance. They found that many of the clinical claims made about the most commonly used eHealth technologies were not substantiated by empirical evidence, and that there was some evidence that introducing these new technologies may on
occasions also general new risks including, for example in the case of e-prescribing the risk of decreased practitioner performance.

The Kings Fund and the Department of Healthcare Networks have been working to explore the opportunities associated with telehealth and telecare as part of the Whole Systems Demonstrator Action Network (WSDAN) (Kings Fund, 2012). The report recognises the lack of evidence with regard to the efficacy and effectiveness of telecare and teleheath to date. The emerging findings of the work undertaken through the WSDAN also suggest that the effective deployment of e-health technologies is dependent on strong leadership and management, recognition of the need to change working practices and promote staff development, and a commitment to developing integrated information systems across health and social care.

A review of telehealth in Scotland undertaken by the Auditor General for Scotland\(^\text{22}\) concluded that the use of technology in the NHS does have the potential to improve the access, quality, delivery and efficiency of healthcare services. It found evidence that:

- Telehealth had the potential to support the delivery of healthcare to a patient at a distance using technology, such as mobile phones, internet services, digital televisions, video-conferencing and self-monitoring equipment.

- Telecare – using technology to support individuals with a range of health and/or social care needs can enable individuals to live more independently and remain at home safely (e.g., falls monitors, motion sensors, alarms).

- eHealth – IT systems, electronic communication and information and records management tools to transmit, store and/or retrieve data electronically for clinical, educational and administrative purposes could improve efficiency and effectiveness of services.

The studies undertaken to date have emphasised that telemedicine is not just an add-on. It is as important to redesign services at the receiving centre to ensure that telemedicine achieves its aim of delivering good healthcare to patients in small remote clinics or at home.

### 5.1.3 Emergency Transport and Pre-hospital Care

Ambulance services are expected to provide a consistently high level of emergency care to all members of the population exhibiting a wide range of medical problems. Included within these will be seriously ill or injured patients requiring early and judicious management and transport to the most appropriate place for treatment. Patients, rightly, expect a high level of service, wherever they live. But, most hospitals are in urban areas, meaning shorter journeys for city and town-based patients, and any delays caused by slow turnaround can be minimised. In addition, during especially treacherous weather, such as snow and flooding, rural areas are often significantly harder to get to than urban ones. At the same time, demand for ambulance services is easier to predict in urban areas because more people live there, there are more incidents to attend and, therefore, more data is available on which to make predictions.

\(^{22}\) A review of telehealth in Scotland (2011) Auditor General for Scotland
The wider role and scope of care offered by emergency ambulance services, together with the need to balance financial constraints has led to ambulance services developing a range of responses such as rapid response services provided by individual paramedics, civilian first aid trained first responders. Some ambulance services have been working to extend the remit of their paramedics, including University-led programmes to train paramedics to undertake a critical care role.

Increasingly patients who are seriously ill or injured are being treated in specialist centres – these patients include those with serious trauma injuries as well as patients who have suffered a stroke or major heart attack. Ambulance services will need to ensure that they have in place staff with the relevant clinical training and systems and procedures which ensure that care is given by the right people at the right time and in the right place.

The University of Sheffield Medical Research Unit undertook a review of the research evidence in relation to pre-hospital urgent and emergency care (Turner, 2010). The main conclusions of the review of the evidence are summarized below:

- There is no research evidence on how best to involve the public in planning emergency care services
- The research to date has concluded that paramedics could not safety and reliably predict which patients needed to Emergency Department Treatment and which could be left at home. All of the authors stated that the development of protocols for patient assessment for non-transportation could make a difference.
- The evidence base for alternatives to an ambulance response or transportation to an emergency department is predominantly focused on interventions where patients can remain in their own home. Studies have been demonstrated difficulties in safety and reliably identifying patients who are suitable for this type of care
- Evidence for the effectiveness of educational interventions to increase the appropriateness of ambulance use is sparse and inconclusive.
- No studies could be identified that had modeled or evaluated an integrated, whole system approach to the provision of pre-hospital care
- There is some evidence that changes in pre-hospital care service delivery, including changing professional roles, can have an impact in terms of meeting the variable needs of patients. These include enhanced clinical triage at time of call, alternatives to transportation to emergency departments and expanding the role of paramedics to provide care at home.
- While triage call prioritization systems can be effective at identifying the level of response required for specific conditions with very clear clinical signs such as cardiac arrest and chest pain, for many less specific conditions the ability of the systems to discriminate between high and low acuity is no better than chance.
- The evidence to support near patient assessment is condition dependent, for example in relation to trauma, the use of evidence based criteria worked little better than chance, however for stroke and
myocardial infarction it is good.

- There is some evidence that rural populations have less access to services than urban populations

### 5.1.3.1 The Role of an Air Ambulance Service

The introduction of air ambulances has been a major development in getting to, and treating patients quickly. Aircraft with two paramedics (air ambulance) is still the most common staffing method and can, in some situations, bring clinical care to the patient more quickly than a road ambulance. It is effect uses an aircraft as an extension of the ambulance service for the transfer of patients from/to hospital.

The principle of a doctor-paramedic team (Helicopter Emergency Medical Service) has also been developed in some areas and, while is still the subject of debate has consistently demonstrated increased survival rates and decreased morbidity when it is in use.\(^{23}\)

While the transfer of patients by air offers advantages in terms of speed, it also results in additional difficulties when compared to traditional road transfers. These include:

- Confined space in the aircraft
- Limited access to the fully packaged patient in some helicopters
- More inherent vibration – increased artefact during monitoring
- Noise – rendering audible monitoring alarms redundant
- Reduced number of specialists able to travel with the patient

Some of the relevant research literature relating to air ambulance services is summarised below. This highlights that there can be significant benefits for those patients who can benefit from rapid transfer, particularly in relation to major trauma and where there is medical input.

**Table 4: Some relevant research literature relating to air ambulance services.**

<table>
<thead>
<tr>
<th>Air ambulance with advanced life support. Institute of Health Economics, Canada; February 2008</th>
<th>Systematic review synthesising evidence on the effectiveness, safety and efficiency of air ambulance transportation (helicopters) with on-board capabilities of advanced life support (ALS).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, patients transported by helicopter showed a benefit in terms of survival, time interval to reach the health care facility, time interval to definitive treatment, better results or a benefit in general. Clinical benefits for trauma and medical patients are mainly impacted by the services available rather than by the type of transport.</td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snooks et al, The costs and benefits of helicopter emergency ambulance services in England and Wales. Journal of Public Health Medicine 1996; 18(1): 67-77</td>
<td>Helicopter transport no faster when a helipad was not available at the destination centre. Secondary transfer by helicopter favourable for patients with intermediate injury severity but should be avoided for extremely serious injuries (1 study). For medical patients, access to coronary care unit improved for cardiac patients (1 study). Transport time from hospitals within a 32-113km radius significantly shorted by helicopter.</td>
</tr>
<tr>
<td>Helicopters for Emergency Medical Services: Clinical Effectiveness, Safety, and Guidelines DATE: 21 December 2001 2011. Canadian Agency for Drugs and Technologies in Health</td>
<td>For the study carried out in England and Wales, there was no evidence of any improvement in vehicle response times when the helicopter service was used in comparison with the land ambulance service.</td>
</tr>
<tr>
<td>Chipp et al. Air Ambulance transfer of adult patients to a UK regional burns centre: Who needs to fly? Burns 2010 Dec: 36(8) 1201-7</td>
<td>The study sought to establish the evidence for the clinical effectiveness and safety of helicopters for emergency medical services. It found limited evidence regarding the clinical effectiveness or safety of helicopters for emergency medical services. No evidence-based guidelines were identified regarding the provision of air ambulance services.</td>
</tr>
<tr>
<td>LeBlanc et al. Geriatric air medical transport: a programme review. Air Med Journal 2002 Jul-Aug; 21*4) 38-40.</td>
<td>Air ambulances offer a fast and effective means of transferring patients to a regional burns centre in selected cases. There is limited data for the beneficial effects of helicopters and survival benefit is seen only in the most severely injured patients.</td>
</tr>
</tbody>
</table>

5.1.4 Non Emergency Patient Transport

Non Emergency transport supports around 1.4 million journeys every year, enabling patients to access outpatient, day treatment and other services at NHS Hospitals.24

Non –emergency patient transport services (PTS) can be defined as non –urgent planned transportation of patients with a medical need for transport to and from a premises providing NHS health care and between NHS healthcare providers25.

In 2000, the Audit Commission undertook a major review of transport arrangements made by local

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24 Welsh Ambulance NHS Trust web site
authorities and health bodies in England and Wales, which included a detailed review of non-emergency patient transport. They published *Improving Non Emergency Patient Transport Services* in 2001 based on the findings and highlighted the importance of ensuring that the need for, and role of, non emergency patient transport was considered in the context of wider travel and access policies, recognising that some patients face great difficulty or hardship in travelling to and from health services. (Audit Commission, 2001)

The Audit Commission suggested that there were a number of key factors to consider in planning and delivering PTS services:

- The principles of service delivery – why do we need a transport service?
- Local interpretations of eligibility – who is to receive the service?
- Safety – are there adequate systems to ensure health and safety of patients on all PTS vehicles?
- Standards for punctuality – what quality of service do we want for patients?
- Patient care and liaison – are the needs and concerns of patients sufficiently well addressed?
- Effective use of resources – are our resources successfully delivery our aims and providing value for money?

In response to the Audit Commission work, the Welsh Assembly Government established a working group to look at non-emergency patient transport services, and one of the issues identified was the need to update the definition of medical need as there was concern that it needed to be more specific with different interpretations being made resulting in inequity across Wales. As a result an All Wales Protocol for Non-Emergency patient Transport Eligibility Criteria was agreed and is summarized below.

**Box 3: All Wales Protocol for Non-Emergency patient Transport Eligibility Criteria**

**ALL-WALES PROTOCOL ELIGIBILITY CRITERIA FOR NON-EMERGENCY PATIENT TRANSPORT**

The following criteria applies only to patients travelling within Wales.

A non-emergency patient is defined as a patient who, whilst requiring treatment, does not need the skills of an ambulance paramedic or technician, but may require trained patient care ambulance personnel to undertake a journey to or from a health facility.

**Principle**

1. A need for treatment does not automatically imply a need for transport.

The following criteria should be applied to assist in the decision to provide transport.

a) The medical condition of the patient is such that they require the skills of ambulance staff or appropriately skilled personnel on or for the journey.

And /or

b) The medical condition of the patient is such that it would be detrimental to the patient’s condition or recovery if they were to travel by any other means.
Eligibility for Non-Emergency Patient Transport
2. A patient will be entitled to hospital transport if they:
   a. Need a stretcher for the journey
   b. Require oxygen or other medical gases during transit
   c. Need to travel in a wheelchair (providing they do not have a specially adapted vehicle or are unable to use the vehicle for that journey).
   d. Are receiving regular dialysis or cancer treatment
   e. Cannot walk without continual support
   f. Cannot use public transport because they:
      g. Have a medical condition that would compromise their dignity or cause public concern
      h. Have severe communication difficulties
      i. Experience side effects as a result of their medical treatment or condition

In applying the above criteria, the following issues should be taken into consideration.

   a. A need for the special facilities provided by a purpose-built ambulance and specially trained staff.
   b. An underlying medical and mobility condition which makes the use of other forms of transport inappropriate.
   c. The nature of the treatment provided means that the use of alternative transport would be detrimental to the patient’s condition or recovery.
   d. Failure to provide transport for a course of treatment would be detrimental to the patient’s health or recovery.
   e. Patients who require a carer during their visit to the treatment centre should make arrangements to meet them at the treatment centre, unless the presence of the carer is essential for the journey.
   f. The address of the patient and the availability of alternative transport in their area is to be a consideration as this may impact on 2.c

Eligibility for Carer/Escort
4. A carer/escort should be considered if:
   a. The patient’s condition is such that they require constant attention or support.
   b. The patient has severe communication difficulties, for example, profound deafness or speech difficulties
   c. The patient has a mental health condition that makes it unsuitable for them to travel unaccompanied
   d. It is a first referral and a carer is attending to provide support to the patient
   e. The patient is receiving renal dialysis or oncology treatment

Note:
   a. Only in special circumstances should more than one carer (i.e. carer and nurse) be transported.
   b. A carer is essential for all children under 18 years of age.

Patients Not Eligible for Non-Emergency Patient Transport
5. Patients who are not eligible for non-emergency patient transport should be advised of alternative methods of transport so they can make their own arrangements to go to the designated treatment centre/hospital. If having tried all alternatives the patient has no other means of transport available to them then they should be considered.

6. Patients making their own way to hospital should be advised that they may be able to claim back some or all of their travel costs if they receive any of the following:
Subsequent Welsh Audit Office and Health Care Inspectorate Wales reviews of the Welsh Ambulance Service in 2006 and 2007 were highly critical of the non emergency patient transport service in Wales, which was found to be variable, fragmented and unable to meet patient need in a responsive and consistent way^{26,27}. As a result the Minister for Health and Social Care commissioned a review, led by Win Griffiths to make recommendations for improvement.

The Griffith Review (Griffith, 2010) made a number of recommendations, which included a recommendation that the Assembly Government should develop a non emergency transport statement and ensure that the reviews findings were incorporated within the National Transport Strategy and Action Plan. It also proposed the establishment of pilot schemes to evaluate the opportunities for greater partnership which will be subject to full evaluation.

Systematic review of the quality and safety issues in relation to non emergency transport concluded that there are three key factors which impact on quality and safety – communication, efficiency and appropriateness of the service^{28}.

5.1.5 Private and Public Transport

Whilst noting the availability of emergency and non emergency patient transport services for eligible patients, the majority of people attending hospital still rely on private or public transport.

*Box 4: Transport to hospital*

**Car Ownership and Access to Public Transport in Wales – Summary of current position**
(Source: The Poverty Site  www.poverty.org.uk)

**Public Transport**
- Among households without a car, two-fifths describe the local bus service as failing to meet their needs for travel to the town centre or the shops while two thirds say it does not meet the need for travel to the hospital. Among households with a car, the proportion in each of these cases is higher still.
- Almost all households - 90% - and irrespective of whether they have car, say that the bus service does not meet the need either for travel at night or travel on Sundays.
- Local bus services do not meet the need for weekday travel for the majority in any part of Wales. Support for the view that local bus services do not meet weekday travel needs is highest in the Valleys, at 80%. At the same time, the proportion of people with daily access to a car is lowest in the

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^{26} Wales Audit Office: Ambulance Services in Wales 2006
The 2004 ‘Living in Wales’ survey included a question about satisfaction with public transport. Although levels of satisfaction were much higher than suggested by the 2004 Welsh Consumer Council Survey, the geographic pattern was similar: high levels of dissatisfaction in rural areas (Powys, Ceredigion, Monmouthshire and Carmarthenshire) and some valleys authorities (Rhondda Cynon Taff and Blaenau Gwent).

### Relating to levels of car ownership

- Levels of car ownership are closely linked with the age and number of adults in the households. Thus, fewer than a tenth of working-age couples lack a car, and only a fifth of pensioner couples. By contrast, half of lone parents lack a car and two thirds of single pensioners. The great majority of these latter two groups are women.
- The proportion of working-age households without a car varies from 26% in Merthyr Tydfil and Blaenau Gwent to 10% in Monmouthshire and Powys.
- Unlike the use of a car for work, car ownership among working-age households is usually quite a lot higher in rural areas, although again Gwynedd is an exception. Car ownership is lowest in the major cities and in the Valleys.
- Physical access to public transport is a major area of concern for older people, people with a disability and people with an illness. Many services are not viewed as having been adapted for people with mobility problems.

A review of transport for health and social care in Scotland highlighted the particular needs of older people, those with long-term health or social care needs and people who live in remote and rural areas and recognized that they may need additional support to get to a hospital appointment or to access services. It concluded that, if transport is not well planned, it can result in unnecessary journeys, missed or late appointments, people staying in hospital longer than they need to and reliance on unplanned options such as taxis.

The report makes a number of recommendations which will be relevant in the context of proposals for change in the configuration of services in Wales including:

- Partners should put systems in place to routinely engage with service users to ensure that their views inform the development of transport for health and social care services
- Partners should assess the impact of proposed service changes on users and other services, taking account of transport needs
- Staff should be well informed about all transport options in their area and provide better information to the public about available transport options, eligibility criteria and charges
- Opportunities to integrate or share services should be maximized
- There should be greater systematic collection of information on the characteristics of people who need transport for health and social care
- The third sector should be involved in planning and delivering transport solutions

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29 Transport for health and social care Prepared for the Auditor General for Scotland and the Accounts Commission, 2011
6 Summary and Conclusion

There are strong political and policy pressures to sustain, and where possible increase, local access to services, particularly those needed in an emergency. There are also good social and quality reasons to provide good access to hospital services – the majority of hospital users and their carers are elderly and many will rely on public transport or on others take them to hospital; having to travel long distances can create difficult journeys.

The evidence with regard to access highlights that decisions regarding reconfiguration of hospital services are complex, and require consideration of many conflicting factors. Data suggest that any changes that increase journey distances to hospital for all emergency patients (including maternity cases) may lead to an increase in mortality for a small number of patients with life-threatening medical emergencies, unless care is improved as a result of the reorganisation. However, even then it is not certain that it would be acceptable to trade an increased risk for some groups of patients, such as those with severe respiratory compromise, for a reduced risk in other groups such as those with myocardial infarction.

There is also an increasing body of evidence that, when presented with clear information and choice, patients and carers want access to safe, high quality services and will be prepared to travel further where they perceive that this will improve outcomes.

People are prepared to travel further to receive services, but only where they are convinced that there are clear benefits in outcome or timeliness. Otherwise they want local services wherever possible.
7 Citations

Institute of Rural Health. (2009). Health in Rural Wales - A research report to support the development of the Rural Health Plan for Wales. Institute of Rural Health.