TRANSPORT TO HEALTH CASE FOR CHANGE

1. INTRODUCTION

1.1 Since October 2025, SEStran has been working closely with its four NHS Boards and NHS Scotland Assure, as well as with consultancy support from Urban Foresight to produce a Case for Change on Transport to Health in South East Scotland; the draft report is attached as Appendix 1.

1.2 The purpose of this report is for the Board to note key findings from the Transport to Health Case for Change and to seek Board's approval to pursue this work into a Transport to Health regional Strategy in 26/27.

2. BACKGROUND

2.1 Transport to Health is an opportunity to reduce transport barriers to accessing healthcare services where and when people need them, reduce missed appointments and improve individual health outcomes. RTPs have a duty under the Transport (Scotland) Acts 2005 and 2019 to work with their Health Boards in considering Transport to Health.

2.2 At a national level in Scotland, Transport to Health has achieved more attention in recent years following a report from the Mobility and Access Committee for Scotland (MACS) in 2019, which found that little progress had been made following an Audit Scotland report in 2011 recommending major improvements to the way older and disabled people accessed healthcare.

2.3 In late 2024, the Scottish Government responded to the MACS report with its Transport to Health Delivery Plan. Among other things, the delivery plan strengthens calls on RTPs to meet with local NHS boards to discuss access to healthcare as well as developing regional plans for transport to healthcare. SEStran is well placed to deliver these commitments, having established an informal learning network with the region's four Health Boards in early 2024. We continue to liaise with Transport Scotland and the Primary Care Directorate to highlight RTPs' role in driving change in Transport to Health. Transport to Health is complex as it falls partially within the remit of many agencies and bodies, given the nature of health service delivery, not to mention the complexities of the transport sector. It is therefore often seen as 'someone else's duty', with no clear responsibility holder.

2.4 This low base of current provision but increasing political profile offers SEStran an opportune moment to develop a Transport to Health Strategy for the south east of Scotland. It is necessary to understand what's happening, and not happening in our region, what we can learn from further afield and engage our Health Boards and other key players in a shared vision. This led us to develop a Transport to Health Literature review in spring 2025, which outlined key challenges and opportunities as well as identified research and data gaps.

2.5 Main challenges included a lack of transport connectivity, costs associated with transport, additional barriers faced by disabled people and organisational and policy-related barriers. Main opportunities consisted of an increased political attention demonstrating potential for a better cooperation across the board, the use of digital technologies to improve transport and health services, and the provision of virtual services.

2.6 The Literature review was the stepping stone for our Case for Change and helped us identified where the focus should be based on the current data gaps. In October 2025, we commissioned Urban Foresight to support the delivery of our Case for Change; this saw the delivery of:

- A desktop review and spatial analysis
- A 6-week public consultation receiving over 1,500 individual responses
- In-person pop-up sessions to engage with patients and staff
- Stakeholder engagement initiatives with the Learning network and beyond

3. FINDINGS OF THE CASE FOR CHANGE

3.1 Key findings from the Transport to Health Case for Change are:

- Access to healthcare across the SEStran region is strongly shaped by transport availability, journey time and reliability
- Public transport journeys to hospital care are typically significantly longer and more complex than equivalent car journeys
- Centralisation of acute and specialist services has increased travel distances and cross-boundary journeys for many patients
- People without access to a car face disproportionate barriers to attending healthcare appointments
- Transport barriers are contributing to missed and delayed appointments, particularly for outpatient and repeat care
- Accessibility challenges continue to limit the suitability of public transport for some disabled people and those with long-term conditions
- Community and demand-responsive transport play a critical role but are unevenly available and not fully integrated
- There is a clear opportunity to better align healthcare planning, appointment scheduling and transport provision
- Improving Transport to Health supports wider objectives on health inequalities, public health and sustainable travel

4. CONCLUSIONS

4.1 There is a clear need to improve Transport to Health in our region. The issues identified in the Case for Change highlight the inequality of access and subsequent negative impacts.

4.2 To address the issues highlighted, it is necessary to develop a Transport to Health Strategy in partnership with our Health Boards, NHS Assure, Transport Scotland, the Primary Care Directorate, Local Authorities, our Partnership Board and expert stakeholders.

5. RECOMMENDATIONS

5.1 To note the findings of the Case for Change report.

5.2 To note that a Programme Initiation Document for the development of a full strategy and implementation plan will be presented to PaSDOS prior to the June meeting of the Partnership Board

Sandra Lavergne
Project Officer
13th March 2026

Appendix 1: Draft Transport to Health Case for Change report

Policy Implications	Progressing the Strategy will deliver policies for the region in Transport to Health.
Financial Implications	This work is budgeted for within the SEStran project budget.
Equalities Implications	Improved and joined up regional direction for Transport to Health would have a positive impact for all. With that said, particular consideration will be needed to make sure that the Strategy actions are appropriate for under-served groups like disabled people and those facing transport poverty. An EqIA has already been done as part of the Case for Change report.
Climate Change Implications	A more joined up Transport to Health approach, and a shift to sustainable modes will contribute to addressing climate change challenges.

APPENDIX 1

Urban Foresight

SEStran Transport to Health – Case for Change

Draft Report

PREPARED FOR

SEStran

Executive summary

This Case for Change sets out the evidence base for developing a Regional Transport to Health Strategy across the South East of Scotland Partnership area, covering NHS Lothian, NHS Fife, NHS Borders and NHS Forth Valley. It responds to national policy expectations for closer collaboration between Regional Transport Partnerships and Health Boards and provides a shared understanding of how transport affects people's ability to access healthcare across the South East of Scotland.

Transport to Health focuses on non-emergency journeys to healthcare (i.e. not emergency ambulances). This ranges from journeys to acute tertiary and secondary care hospitals to local primary care services like GP surgeries, pharmacies and dentists.

The study draws together demographic and socio-economic analysis, travel-time modelling, public consultation evidence from over 1,500 respondents, and engagement with NHS partners, local authorities and community transport providers. Together, this evidence shows that while access to primary care is generally good across much of the region, transport barriers to hospital-based and specialist care are widespread, unevenly distributed, and fall disproportionately on people without access to a private car.

Why Transport to Health matters in the SEStran region

The SEStran region includes dense urban areas, expanding commuter towns, coastal settlements and extensive rural communities. While GP services are largely community-based, secondary and tertiary care is increasingly concentrated in a small number of hospital sites. As a result, many residents must travel long distances, often across local authority or Health Board boundaries, to access hospital care.

Travel-time modelling shows that public transport journeys to hospitals are typically two to four times longer than equivalent car journeys and frequently involve indirect routes, multiple interchanges and extended waiting times. These challenges are hardest felt by older people, disabled people, carers and those attending regular outpatient appointments.

Public consultation evidence demonstrates that these barriers affect access to care. Around one third of respondents across the region reported missing or delaying a healthcare appointment due to transport issues, rising to over 40% in NHS Fife. Unreliable or infrequent services, indirect routes, parking pressures and accessibility barriers were the most commonly cited factors.

These issues reinforce wider inequalities, particularly for people without access to a private car, disabled people and residents of rural and semi-rural areas.

What the evidence shows

Across all four Health Boards, a consistent set of challenges emerges:

- Travel to centralised acute hospital facilities by its nature presents greater challenges to patients than local primary care journeys, requiring careful planning to ensure complex and long journeys can be made with maximum convenience and efficiency.
- People without access to a private car face disproportionate barriers, reinforcing transport-related health inequalities.

- Transport barriers contribute to missed and delayed appointments, especially for outpatient and specialist care.
- Accessibility issues limit the suitability of public transport for some users, even where services exist.
- Parking pressures at major hospitals influence travel behaviour and increase stress, reinforcing reliance on private cars.
- Community and demand-responsive transport play a critical role, but capacity, funding and coordination constraints limit their effectiveness.

Problems, Opportunities, Issues and Constraints

Using a Problems, Opportunities, Issues and Constraints (POIC) framework in line with Scottish Transport Appraisal Guidance, the report identifies:

- Key problems, including long and indirect hospital journeys, car dependency, transport-related non-attendance and accessibility barriers.
- Opportunities to better align healthcare planning and transport provision, strengthen community and demand-responsive transport, improve information and booking, and reduce avoidable travel through more local or digital care delivery where appropriate.
- Issues requiring further consideration, such as misalignment between appointment scheduling and transport availability, fragmented transport information and under-integration of community transport.
- Constraints, including rural geography, service centralisation, funding limitations and institutional boundaries across transport and healthcare systems.

This structured assessment provides a clear bridge between the evidence base and the development of future interventions.

Transport Planning Objectives

Drawing directly from the POIC analysis, the report sets out a focused set of Transport Planning Objectives. These focus on reducing journey time and complexity for hospital care, improving access for people without a car, addressing accessibility barriers, reducing transport-related missed appointments, improving coordination and clarity of information, strengthening community and flexible transport, and supporting a more sustainable and efficient Transport to Health system.

These objectives provide a clear framework for the next stage of work and will guide option generation, sifting and appraisal.

Next Steps

This Case for Change establishes a shared evidence base and clear rationale for intervention. The next stage will focus on developing a Regional Transport to Health Strategy, including refining Transport Planning Objectives, identifying and appraising potential interventions in line with Scottish Transport Appraisal Guidance, and working with partners to develop a coordinated and deliverable approach.

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Introduction

Purpose of the report

SEStran is the statutory Regional Transport Partnership for the South East of Scotland and is responsible for setting the strategic direction for transport across its eight constituent Local Authorities. National policy now sets clear expectations for Regional Transport Partnerships and Health Boards to collaborate on improving Transport to Health. In response, SEStran and the four Health Boards (NHS Lothian, NHS Fife, NHS Borders and NHS Forth Valley) in the region have agreed to develop a regional Transport to Health Strategy. This Case for Change represents the first stage in that process.

A transport system that enables people to reach healthcare when they need it is fundamental to individual wellbeing, social equity and the effective functioning of the health service. This report presents the evidence base for the Transport to Health Case for Change in the South East of Scotland. It brings together demographic, socio-economic, geographic and transport data, alongside public and stakeholder insight, to understand how people currently travel to primary, secondary and specialist care, and the barriers they encounter.

The report provides a comprehensive assessment of existing Transport to Health challenges across the SEStran region and establishes the foundation for developing a coordinated regional approach.

Scope of the study

The study covers all eight local authority areas within the SEStran region, encompassing the City of Edinburgh, East Lothian, Midlothian, West Lothian, Fife, Falkirk, Clackmannanshire and the Scottish Borders. Together, these areas reflect a wide range of urban, semi-urban and rural contexts in which Transport to Health challenges vary significantly.

The study examines transport access to a range of healthcare services, including:

- GP practices and primary care services
- Secondary care and hospital outpatient departments
- Tertiary and specialist care services
- Community-based and non-emergency services

For the purposes of this study, primary, secondary and tertiary healthcare services are defined in line with Scottish Government and NHS Scotland usage. Primary care refers to community-based services that are typically the first point of contact with the NHS, such as GP practices, community nursing, pharmacy and allied health professionals. Secondary care comprises specialist services, usually delivered in hospital settings and accessed by referral from primary care, while tertiary care refers to highly specialised services provided in regional or national specialist centres.

The study considers journeys undertaken by patients, carers and people attending appointments on behalf of others, but does not include staff travel. All modes of transport are within scope, including public transport, community transport, demand-responsive services, active travel, private car use and taxi travel.

Why this work matters

Transport shapes whether people can reach care in a timely way. The South East of Scotland contains a mix of dense urban neighbourhoods, expanding commuter towns, coastal settlements and remote rural communities. Across such varied places, people have very different experiences of travelling to healthcare.

Those who rely on public transport, who have mobility impairments or who live far from major hospitals face the greatest pressures. Appointment times that do not match available services, indirect routes, long journeys and reliance on informal lifts were all highlighted during this study.

These challenges feed into wider system impacts. Car parking at major hospitals often operates near capacity and contributes to delays, missed appointments and stress for patients and staff. Across the region, around 130,000 outpatient appointments[1] are missed each year. Although transport is not the only reason for non-attendance, it is recognised as a significant contributing factor.

There is no single Scotland-wide estimate of the financial cost of missed appointments, but commonly cited benchmarks provide an indication of scale. NHS England estimates that each missed outpatient appointment costs £30 to £40,[2] while NHS Greater Glasgow and Clyde reports average costs of £233 per missed appointment.[3] Applying these ranges to the SEStran region suggests that missed appointments may cost the NHS between £4.1 million and £31.3 million annually, noting that only a proportion of these missed appointments are transport related.

A literature review of existing Transport to Health research was undertaken by SEStran earlier in 2025 to inform the initial understanding of regional challenges. The review found that while there is substantial national commentary on transport barriers and missed appointments, evidence specific to the South East of Scotland is limited.

Much of the available work focuses on national averages or single care settings and provides little insight into local travel behaviour, cross boundary flows, the role of different transport modes or the lived experience of patients and carers. The review also highlighted gaps in data, including the cost of transport related missed appointments and the accessibility of non-emergency services. These gaps reinforced the need for a more detailed, region-specific evidence base, which this Case for Change sets out to achieve.

Better Transport to Health provision helps promote fairness, improves overall public health and reduces unnecessary strain on clinical services. It also supports broader regional and national goals related to climate change, air quality and social inclusion. Although the region already hosts a mix of public transport, community-based provision and demand responsive services, availability remains inconsistent. Service patterns are often poorly aligned with the location or scheduling of healthcare and innovative practices are not yet applied consistently.

A regional approach is needed to address these challenges. The findings presented in this report create a clear and shared understanding of where the most significant access challenges lie and

[1] SEStran (2025) Transport to Health: Literature Review
[2] NHS England: The Florence Road Surgery (2025) Understanding the Impact of Missed Appointments on the NHS
[3] NHS Greater Glasgow and Clyde (2024) Virtual consultations could reduce number of missed NHS appointments

where improvements could deliver the greatest benefit. This will support the development of a regional Transport to Health Strategy in the next phase of work.

How this report will be used

This Case for Change will be used to identify and organise the problems, opportunities, issues and constraints associated with Transport to Health across the region. It will also shape Transport Planning Objectives that are consistent with national appraisal requirements and guide the development of future options. The work will be taken forward in collaboration with NHS Boards, Local Authorities, transport operators, community organisations and other partners involved in supporting access to healthcare.

Policy context

Transport to Health is shaped by a wide range of national, regional and local policy commitments. Together, these set the strategic direction for improving accessibility, reducing inequalities and supporting the delivery of a more efficient and sustainable health and transport system. The policy context for this work is summarised below.

National policy

Transport (Scotland) Act 2005

The transport (Scotland) act 2005 established Regional Transport partnerships (RTPs) as statutory bodies with responsibility for preparing and delivering regional transport strategies. The act places duty on RTPs to develop transport strategies that contribute to sustainable development, improve social inclusion and promote equal opportunities.

While the act does not place direct transport delivery duties on Health Boards, it provides the statutory framework within which RTPs, and Health Boards are expected to cooperate. In practice, this creates a shared responsibility to ensure that regional transport planning supports access to key services, including healthcare. The Act therefore supports the collaborative working between RTPs, local authorities and NHS boards in improving access to health services across Scotland.[4]

Transport (Scotland) Act 2019

The 2019 Transport (Scotland) Act gives Health boards several responsibilities to consider non-emergency patient transport. One of the policies stated is as follows:

> 120. Health boards: duty to have regard to community benefit in non-emergency patient transport contracts

This requires Health Boards to consider, in addition to the contract's primary purpose, the economic, social, and environmental wellbeing impacts of non-emergency transport agreements.

The Transport Act also states the following policy:

> 121. Health boards: duty to work with community transport bodies

This requires Health Boards to work with community transport organisations in their jurisdiction when providing non-emergency patient transport services. The policy additionally requires Health Boards to publish an annual report which demonstrates the steps they have taken to comply with this policy. The report should also demonstrate how effective and cost-effective non-emergency transport services have been in the board area.

This report will engage will community transport organisations and Health Boards to assess the constraints and opportunities of improving coordination between community transport organisations and Health Boards. This includes the utilisation of regional forums through the Regional Transport Partnership.

[4] Transport (Scotland) Act 2005: https://www.legislation.gov.uk/asp/2005/12/contents

Scottish Government Transport to Health Delivery Plan (2024[5])

This plan sets out commitments to tackle the issue of Transport to Health including 16 commitments which describe how Health Boards should work alongside RTPs:

- → Commitment 11 states that NHS Delivery Plans should include consideration of how best to work with Regional Transport Partnerships and transport officers from Local Authorities
- → Commitment 12 states RTPs should convene stakeholder groups with a remit on Transport to Health and Regional Transport Strategies should include appropriate consideration of Transport to Health Issues
- → Commitment 19 states the Scottish Government will support RTPs to develop their own plans around Transport to Health.

Other actions to be taken by the Scottish Government include reviewing the Scottish Ambulance Service' (SAS) Equalities Impact Assessment of Patient Transport, and to review the Patient Needs Assessment which determines if patients are eligible for transport.

Working through the Re-mobilise, Recover, Re-design Framework and the Digital Health and Care Strategy the Scottish Government will seek to offer a greater number of accessibly designed digital services and care closer to home, reducing the need to travel.

The Scottish Government will stipulate in Health Boards' Annual Delivery Plans that patients must have access to all information on relevant transport, community transport and reimbursement entitlement. On top of this the potential for appointment transport information to be incorporated into the NHS inform app and Traveline will be considered.

Overall, the plan sets out a variety of commitments that seek to improve collaboration and coordination between different sectors and organisations to improve transport journeys to healthcare as well as overall public, patient and community transport accessibility.

National Transport Strategy 2 (NTS2)

The National Transport Strategy 2 maps the vision for Scotland's transport system to 2040. The four main priorities of the strategy are:

1. To reduce inequalities
2. To take climate action
3. To help deliver inclusive economic growth
4. To improve our health and wellbeing

The strategy mainly focuses in improving health and wellbeing through increasing activity levels through active travel and reducing air pollution. However, under the reducing inequalities by providing fair access to services remit the strategy does commit to:

> "Improve sustainable access to healthcare facilities for staff, patients and visitors" – NTS2

[5] https://www.gov.scot/publications/transport-health-delivery-plan/

The Scottish Government views the path to improving Transport to Health as a way of reducing inequalities. It places an emphasis on the challenges faced by older and disabled people:

"As a society, it is important that older and disabled people can plan and get to their GP or hospital without facing physical barriers and enduring distress, anxiety or additional transport costs."

The strategy states the Scottish Government will ensure that sustainable access is embedded in the planning process for hospitals and health services. A different approach to planning and delivering health services will also reduce the need to travel to healthcare.

Strategic Transport Projects Review 2 (STPR2)

The equality impact assessment (EqIA) for the STPR2 includes consideration of how projects will improve access to services, including healthcare. When accessing each strategic project one of the objectives is "Health and Health Inequality". Included in this is the guide question:

"Will the option/intervention/package improve access to healthcare, in particular for those with protected characteristics and demographic groups facing structural inequalities?"

This demonstrates that Transport to Health is a consideration when assessing major strategic transport projects.

National research and evidence

Mobility and Access Committee for Scotland (2019)

The issue of Transport to Health has risen in prominence again since the Mobility and Access Committee for Scotland (MACS) produce the Transport to Health and Social report in December 2019.[6] The report focused on barriers disabled and older people face when accessing health and social care facilities, it brought together a roundtable including Disabled People's Organisations, Community Transport Association, Transport Scotland, NHS Boards and surveyed over 1,000 disabled people.

Some selected findings of the report include:

- No progress had been made on this issue since the 2011 Audit Scotland[7] report on the same issue
- 98% of 849 older and disabled people surveyed said they faced transport barriers accessing health and social care appointments
- A lack of coordinated planning between the NHS, Local Authorities, the Scottish Ambulance Service, Regional Transport Partnerships and Community Transport Providers
- Poor signposting to alternative transport organisations
- Scottish Ambulance Service (SAS) overstretched and filling the gaps caused by poor public transport. SAS' changes to Patient Needs Assessment and the loss of the SAS voluntary car have reduced the number of bookings SAS can accept

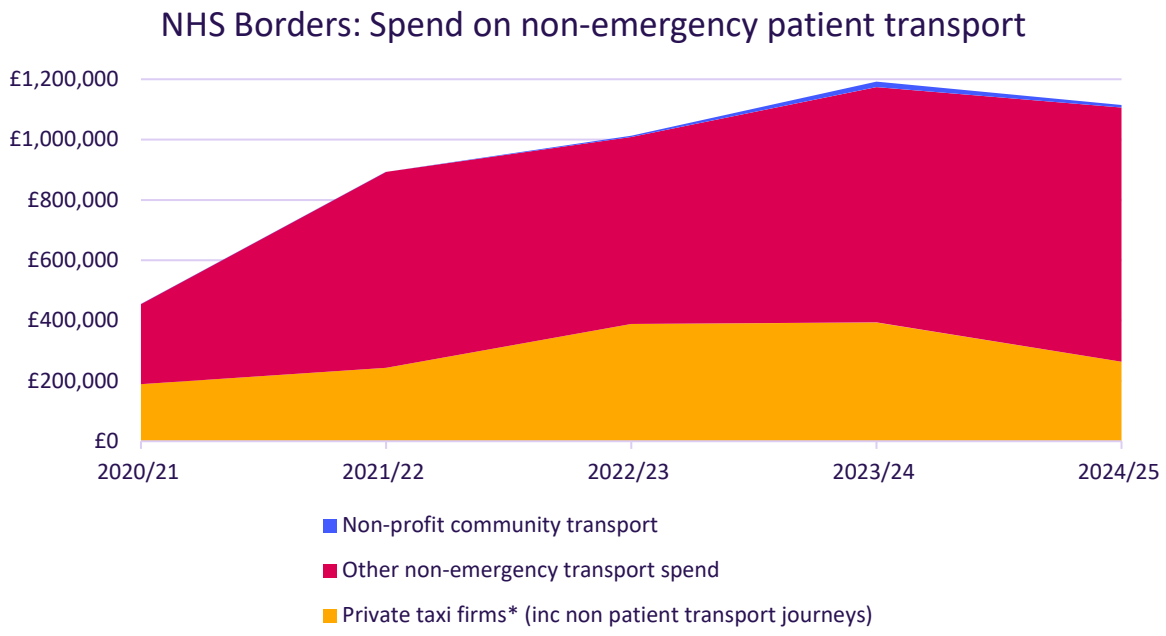
[6] Mobility and Access Committee, 2019, Transport to Health Report
[7] https://audit.scot/publications/transport-for-health-and-social-care

- Community Transport organisations are filling in some of the gaps, but their work goes unacknowledged. Some requests they received go unfulfilled and they have to charge passengers by the mile making the service unaffordable to many
- The overall public transport system and infrastructure is not designed towards disabled and older people accessing healthcare

Community Transport Association (CTA)

In 2025 the Community Transport Association published a report based on a series of Freedom of Information requests to NHS boards in Scotland.[8] It focused on the provision in the Transport (Scotland) Act 2019 which stated that Health Boards have a duty to work with community transport bodies. The report found that most NHS boards are either only partially compliant or non-compliant with the legislation.

The FOIs included some information on non-emergency transport spend. However, this information varies between Health Boards and spend on taxis for patient transport is not differentiated from taxi spending on other operational requirements. NHS Borders is one the Health Boards which had more complete data on non-emergency transport spending:



Regional policy and related schemes

SEStran Regional Transport Strategy (RTS)

The Regional Transport Strategy for SEStran provides the strategic framework for management and investment in the transport network to 2035. One key aspect for the next 10 years the strategy considers is the trend of increasing demand for travel to healthcare.

The RTS states that services should be located with connectivity to deprived areas in mind (e.g. health provision should be located with connectivity to health-deprived communities in mind).

[8] https://ctauk.org/healthy-communities-scotland

Analysis as part of the RTS found that areas with both poor connection to public transport and high health deprivation included areas postcodes around the periphery of Edinburgh, as well as in the Scottish Borders, Clackmannanshire and Levenmouth in Fife.

SEStran Regional Bus Strategy

The SEStran Regional Bus Strategy (SRBS) sets out the policy vision for all public bus services in the region. This has significant relevance for Transport to Health, since bus transport is the second most common method of travel to healthcare appointments.

The strategy aims for transport governance to have stronger integration with economic, planning, and health priorities. The vision is underpinned by three key areas of improvement:

- → Improve level of service
- → Improve affordability
- → Improve service quality

To improve the level of service the strategy commits to engage on the potential implementation of core equitable service stands for intra-SEStran, inter-urban, and cross boundary connectivity, including important movements outside of the RTP area. These service standards will be based on an audit of the connectivity of settlements in the region. Additionally, RTS Policy 9.2g states:

> "Bus improvements should support access to healthcare facilities where practical and appropriate."

SRBS policies aimed at improving the level of service, service affordability and service quality will help to make bus services which connect healthcare more accessible and convenient.

SEStran Transport to Health literature review

The Transport to Health literature review completed by SEStran previous to this report identified several research gaps. This report addresses some of the research gaps identified; the extent and nature of this coverage are outlined in Table 1 below:

Table 1: Research gaps and report coverage.

Research Gap	Description	Addressed by this report?
Transport mode share for different types of journeys to healthcare services in the SEStran region.	The last SHS Transport and Travel report to capture this information was in 2011 at a national scale, but even then, it does not appear to have been provided at the RTP or Local Authority level, potentially due to sample sizes.	The response to the survey by over 1,500 SEStran residents includes questions on: ↘ Transport mode share to reach healthcare appointments (primary and secondary modes) ↘ Self-reported journey times to different types of health care appointments (GP, pharmacy etc.) ↘ Frequency of travel to different types of healthcare appointments

Research Gap	Description	Addressed by this report?
Car and public transport distances to other types of primary care.	Analysis carried out using SIMD data has focused on access to GP services and hospitals in the SEStran region. While important, other types of healthcare are not captured by this analysis, such as pharmacies and dental practices.	The self-reported journey times to each type of healthcare (pharmacies, dentists etc.). 1,340 of the responses contain postcode district data which can be confidently assigned to Local Authorities and on the postcode district level to gain a spatial understanding of journey times. This data can be further split into those who primarily use car or public transport.
Alternative modes of transport to healthcare sites	While the 2023 SHS asks how people get to the GP and asks people who always drive to the GP if they can use any other modes of transport, it does not ask about other types of healthcare service. It also does not provide a breakdown of the data for the SEStran region. Another insight missing from the data is how many people own a car but choose to take another mode of transport to healthcare.	The survey doesn't provide data on mode share by type of appointment. However, the survey contains car ownership data and primary and secondary mode choice preference for healthcare journeys, so the proportion of car owners who choose to use public transport can be calculated.
Quantifying the scale of the parking problem at hospital sites.	At the moment there is plenty of anecdotal evidence around parking issues at NHS sites. Further research could attempt to quantify on a more rigorous basis how long patients spend trying to find parking and what implications this has.	This report does not include automatic number plate recognition (ANPR) data. However, the proportion of respondents who cite parking as a barrier to accessing healthcare has been provided through the survey.
Transport cost barriers to accessing healthcare services	There is little research examining the cost of transport specifically, as opposed to transport more generally, as a barrier to accessing healthcare in a Scotland or UK context.	Our survey asks respondents to say if transport costs affect their ability or decision at attend healthcare. Responses to this question can be filtered by a number of characteristics including car access and bus pass recipients.
Quantifying the cost to the NHS of transport-related missed appointments in the SEStran region.	While the reasons for missing appointments are complex, if transport can be pinpointed as a reason for particular missed appointments, this could provide motivation for the NHS to fund transport services.	Our survey asks respondents, "Have you ever missed or delayed a healthcare appointment due to transport issues?". As well as the reason for missed / delayed appointments has been given. The cost to the NHS of these missed appointments could be extrapolated but the proportion of all missed/delayed appointments that are due to transport issues cannot.
People who avoid booking healthcare appointments altogether.	Inherently a difficult phenomenon to capture, understanding how many people are put off by poor transport	The survey doesn't ask about those who avoid booking healthcare appointments altogether. However, an analysis of qualitive

Research Gap	Description	Addressed by this report?
	from booking appointments could provide further basis for a Transport to Health strategy.	responses could provide some information as to the extent of this phenomenon.

SEStran People and Place Programme

The SEStran People and Place Programme provides an important complementary context for Transport to Health across the region. In 2024/25, SEStran received £5.3 million to deliver a wide range of projects aimed at increasing walking, wheeling and cycling and improving local accessibility.

Over 100 projects were supported, including cycle training, access to bikes, community-led walks, street audits and public realm improvements. Many of these initiatives directly support Transport to Health objectives by improving confidence, safety and physical accessibility for short everyday journeys, including travel to GP practices, pharmacies and community health facilities.

Several projects also focused on improving the accessibility of streets and walking environments near health and social care sites, helping to reduce physical barriers for older people, disabled people and those with long-term health conditions. By strengthening local connections and enabling more people to travel actively where appropriate, the programme contributes to reducing car dependency for shorter healthcare trips and supports wider public health outcomes.

The People and Place Programme therefore provides a practical delivery mechanism that aligns closely with the objectives of this Case for Change and demonstrates how place-based transport interventions can support improved access to healthcare, particularly at a local and community level. The programme is ongoing and will continue to deliver benefits into 2026/27 and beyond.

Approach and methodology

This Case for Change has been developed through a structured, evidence-driven and iterative process that brings together quantitative analysis, spatial modelling, public insight and engagement with organisations involved in Transport to Health.

The approach reflects Scottish Transport Appraisal Guidance (STAG) principles and builds on the findings of the Literature Review undertaken earlier in 2025.

The methodology used for this study is summarised below:

Evidence review

A wide range of existing datasets and published material was reviewed to develop a consistent baseline for the SEStran region. This included demographic and socio-economic indicators, health activity data, transport network information and relevant national and regional policy documents.

The Literature Review identified several gaps in available research, particularly around local travel behaviour, missed appointments and the lived experience of users, which helped inform the design of the remaining stages of the study.

Geographic and accessibility analysis

Geographic Information Systems (GIS) were used to analyse how people across the SEStran region currently access healthcare services. Spatial analysis combined healthcare site locations, population and demographic data, and details of the region's public transport and road networks. Travel time modelling was undertaken to compare access by different modes, including public transport, private car and active travel.

This analysis provided a detailed understanding of how accessibility varies between urban, semi-rural and rural areas, and where transport related barriers are most likely to occur. It also highlighted cross boundary travel patterns between Local Authorities and Health Boards. The outputs of this work provide the geographic foundation for the Problems, Opportunities, Issues and Constraints (POIC) assessment and help explain how transport barriers vary between places and population groups.

Public consultation and stakeholder insight

A region wide public consultation was carried out between October and November 2025. More than 1,500 responses were received, providing a substantial evidence base of lived experience across all eight Local Authority areas.

The consultation explored how people travel to healthcare, what challenges they face, how these differ by type of appointment and the impact of cost, journey duration and transport reliability. Both quantitative and qualitative responses were analysed, with postcode data used to generate insights at local authority and Health Board level and to test geographic patterns identified through the spatial analysis.

Stakeholder engagement

Engagement was carried out with a range of organisations involved in Transport to Health across the region. This included NHS Boards, Local Authority transport teams, community transport operators, public transport providers and members of the SEStran Transport to Health Learning Network, which brings together representatives from NHS Scotland Assure, the Scottish Ambulance Service and partner Health Boards.

Stakeholder input was used to sense-check emerging findings, provide operational context, and identify practical opportunities and constraints affecting delivery. Their perspectives were used to complement and contextualise the findings from the geographic analysis and public consultation.

Equality considerations

An initial Equality Impact Assessment (EqIA) has been undertaken to inform this Case for Change, reflecting its early appraisal stage.

Equality and socio-economic considerations have been embedded throughout the evidence review, analysis and engagement activities. This has supported the identification of potential inequalities in access to healthcare and transport across the SEStran region, with particular regard to groups more likely to experience transport disadvantages.

The EqIA has informed the identification of problems, opportunities and issues within the Case for Change and highlights where further evidence, mitigation and engagement will be required at subsequent option development and appraisal stages. The assessment has been undertaken in line with STAG, the Equality Act 2010 and the Fairer Scotland Duty.

Analytical framing

All findings were synthesised using a Problems, Opportunities, Issues and Constraints framework, in line with STAG guidance. This ensures that the challenges identified in the evidence base are considered alongside future opportunities and practical constraints. The POIC framework also provides a clear structure for developing Transport Planning Objectives in the next phase of work.

Regional context

Transport to Health in the South East of Scotland is influenced by the region's geography, demography, socio-economic conditions, transport infrastructure and the configuration of healthcare services.

Understanding these factors is essential to explaining why transport barriers emerge in some areas and why experiences vary across the region. This section provides an overview of the wider context that influences access to healthcare for people living in the SEStran area.

Transport system overview

The SEStran region is served by an extensive road network and a varied but uneven public transport system. The left-hand map in Figure 1 illustrates the strategic road hierarchy, including motorways, A roads and B roads that form the backbone of regional and cross-boundary travel. These corridors provide generally good connectivity to major towns and to the region's acute hospitals although reliance on the road network is significantly higher in rural areas where alternatives are limited.

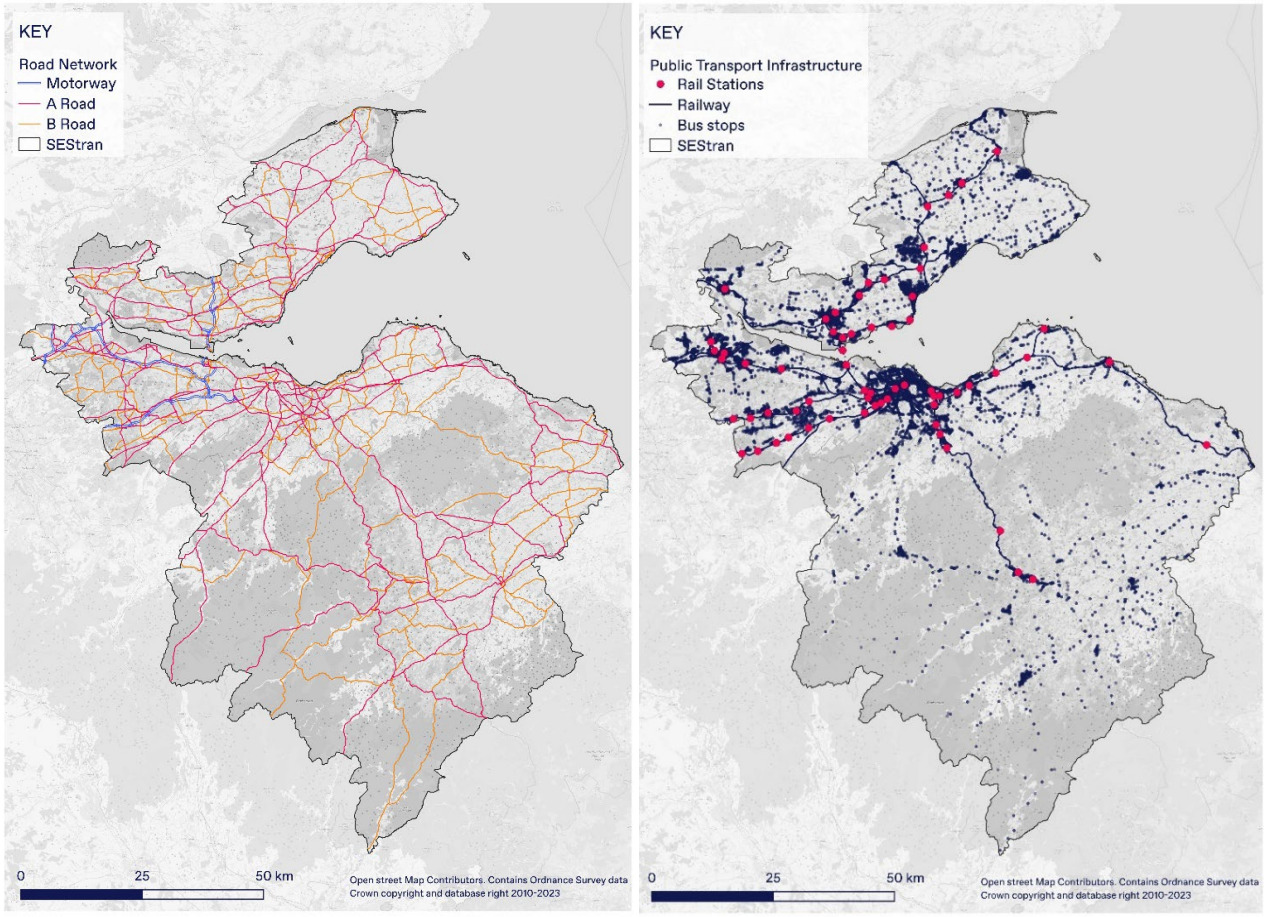


Figure 1: SEStran Road Network (Left) and Public Transport Infrastructure (Right)

The right-hand map shows the distribution of public transport infrastructure. Rail stations are rail corridors are concentrated around Edinburgh, Fife, Falkirk and the Borders railway corridor, providing

strong links into the capital and between major settlements. In contrast, much of rural Fife, Clackmannanshire and the Scottish Borders sit at considerable distance from the rail network.

Bus stop density is highest in Edinburgh, West Lothian, Midlothian and the larger towns in Fife and Falkirk. However, the map also highlights large areas with sparse bus coverage, especially in rural parts of the Borders and north-eastern Fife. These patterns illustrate the structural challenges faced by residents who depend on public transport, particularly when travelling to hospital sites located outside their immediate communities.

Healthcare system overview

Healthcare provision across the SEStran region comprises a network of GP surgeries, community hospitals and health centres, supported by several major acute hospitals located in each of the four NHS Board areas. Figure 2 illustrates the distribution of these facilities and shows the geographic footprints of NHS Lothian, NHS Fife, NHS Forth Valley and NHS Borders, highlighting the spatial relationship between population centres and the healthcare estate.

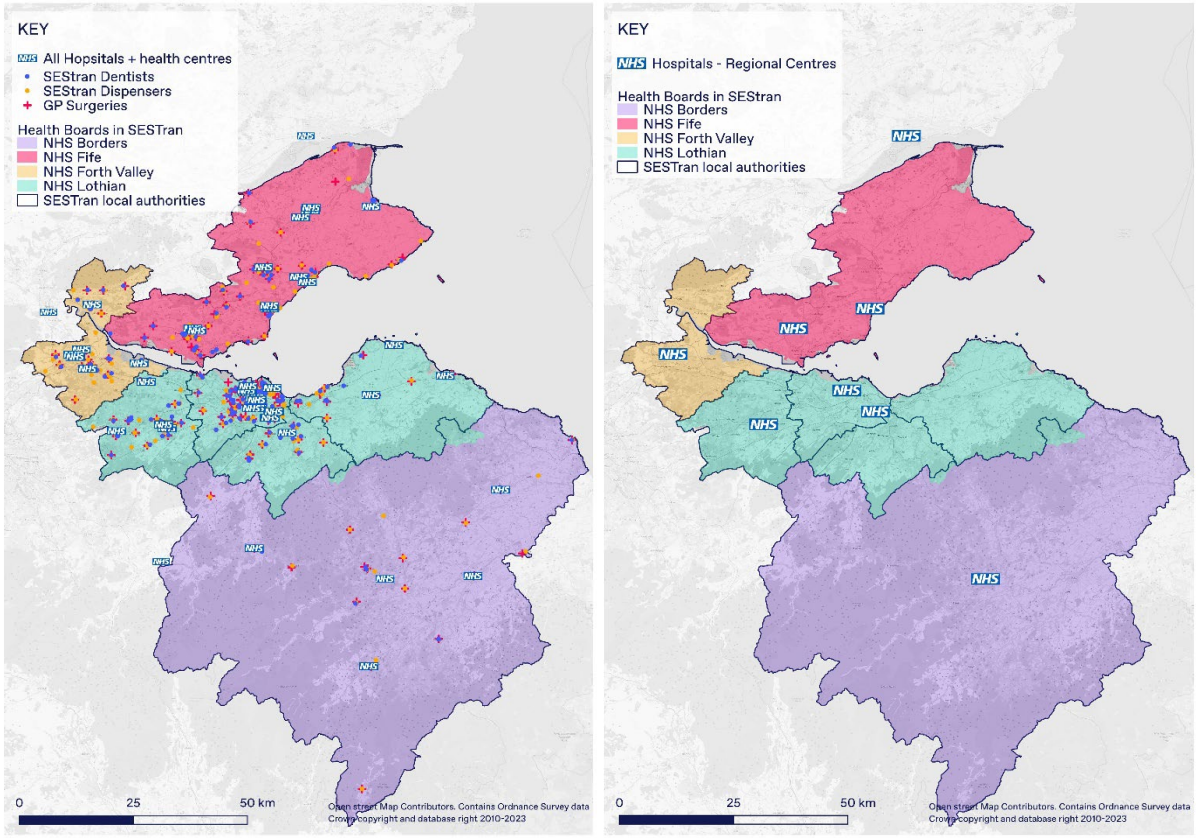


Figure 2: Primary Healthcare (Left), Regional healthcare centres providing Secondary and Tertiary Care (Right)

GP surgeries are generally widespread and closely aligned with where people live, providing relatively local access for routine primary care. However, smaller settlements in rural areas, particularly in parts of the Scottish Borders, Clackmannanshire and eastern Fife, sit at greater distances from their nearest GP practice. For residents without access to a car, this can increase reliance on public, community or family transportation to attend healthcare appointments. Major hospitals, shown in Figure 2 as NHS hospital markers, are more spatially concentrated.

Acute and specialist care is delivered from key sites including the Royal Infirmary of Edinburgh and Western General Hospital in Edinburgh, Victoria Hospital in Kirkcaldy, Forth Valley Royal Hospital in Larbert and Borders General Hospital in Melrose. This degree of centralisation is necessary for clinical quality and efficiency, but it also means that many residents must travel beyond their local authority area, and in some cases beyond their Health Board boundary, to access hospital-based or specialist services.

Community hospitals and healthcare centres supplement this network by offering local outpatient clinics and minor procedures, but the availability and scope of services vary between sites. As a result, patients often still travel to acute hospitals for diagnostics, specialist appointments and higher-level care.

Regional geography and settlement patterns

The SEStran region spans eight local authority areas with diverse settlement patterns, ranging from dense urban neighbourhoods in Edinburgh and Falkirk to dispersed rural communities in the Scottish Borders, Clackmannanshire and eastern Fife. These spatial differences strongly influence the types of transport options available to residents and the practicality of accessing healthcare without a private car.[9]

Figure 3 illustrates this variation, showing the Scottish Government's Urban-Rural Classification (left) alongside population density (right) across the region. The maps highlight the concentration of larger settlements along key transport corridors and the extensive areas where population is dispersed across small towns, villages and remote rural settings.

Urban areas typically benefit from more frequent and comprehensive bus services, while rural areas experience lower service density and reduced availability, particularly outside peak times.[9][10] However, journeys to major hospitals can still be indirect, often requiring interchange or travel through congested corridors.[11]

Semi-rural and commuter towns in West Lothian, Midlothian and coastal East Lothian typically have reasonable daytime bus provision during core hours, but service frequency often reduces significantly in the early morning, evening and at weekends.[12] Residents in these areas may therefore rely more heavily on private cars for hospital appointments located outside their immediate communities.

[9] Scottish Government (2020) Scottish Household Survey – Travel and Transport in Scotland
[10] Transport Scotland (2025) Scottish Transport Statistics 2024: Chapter 2 – Bus and Coach Travel
[11] SEStran (2025) Regional Bus Strategy – Case for Change
[12] SEStran (2025) Transport to Health Literature Review

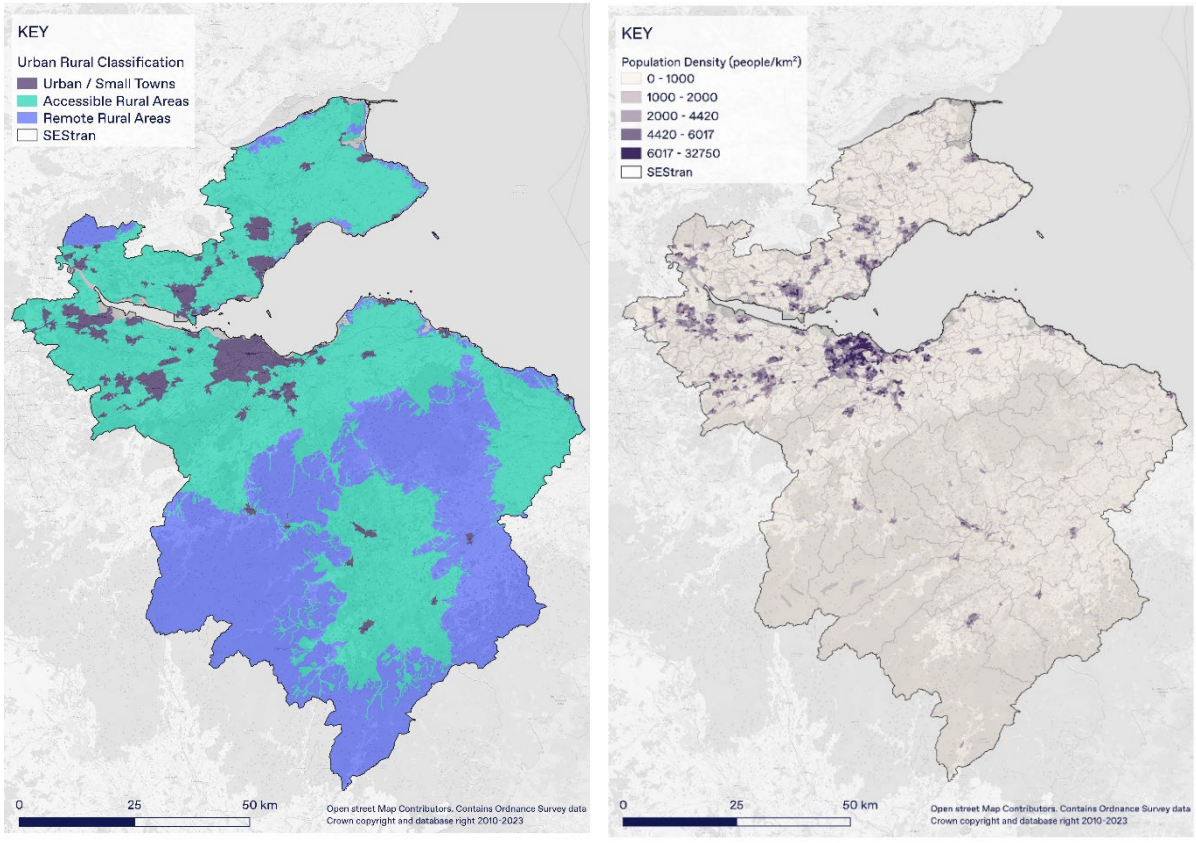


Figure 3 Urban–Rural Classification (left) and Population density (right) across the SEStran region

These constraints mean that many rural residents depend on private, community or informal transport to reach healthcare. In this context, informal transport refers to privately arranged, unpaid or non-commercial travel outside statutory services. This reliance can exacerbate disadvantage for people without access to a car, those with mobility impairments, and those who require frequent appointments.[13]

Demographics and population change

The SEStran region is home to over 1.6 million people. but demographic trends vary significantly between local authority areas. These differences directly influence travel demand, patterns of healthcare use and the types of Transport to Health support required.

Figure 4 shows the proportion of residents aged over 75, highlighting large areas in the Scottish Borders, Clackmannanshire and eastern Fife where older populations are most concentrated and which coincide with more rural settings. Typically, public transport frequency declines and distances to services increase in these settings. This age group is particularly relevant, as older adults tend to require more regular healthcare appointments and are less likely to continue driving long distances as they age, increasing dependence on public, community or informal transport networks.[14]

[13] https://publichealthscotland.scot/population-health/environmental-health-impacts/transport-and-health/why-is-transport-important-for-health/
[14] https://www.transport.gov.scot/publication/health-inequalities-impact-assessment-hiia-nts-delivery-plan/key-issues-and-evidence

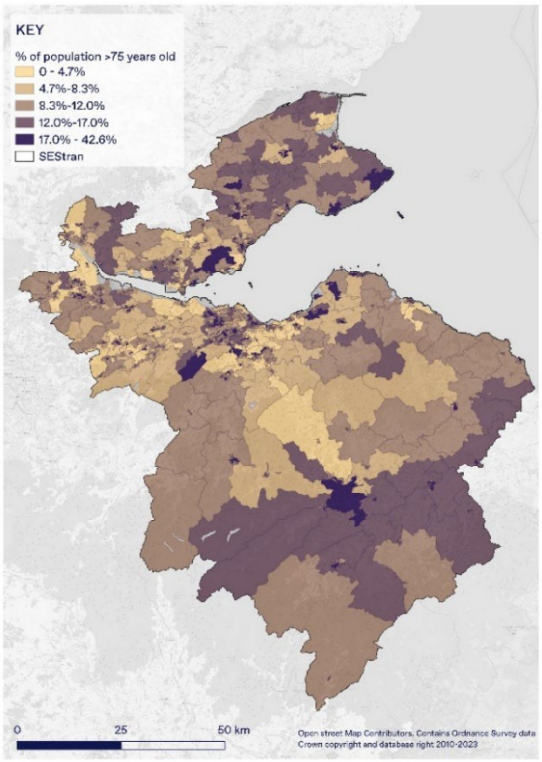


Figure 4: Proportion of residents aged 75 and over by area

Figure 5 presents the wider age structure by local authority. Edinburgh has the youngest profile, with a high proportion of working-age adults and comparatively fewer residents aged over 65 and over. West Lothian, Falkirk and Midlothian also show younger age distributions, reflecting continued residential expansion. In contrast, the Scottish Borders and Clackmannanshire have some of the highest proportions of older adults in the region, contributing to elevated transport need for primary and secondary care.

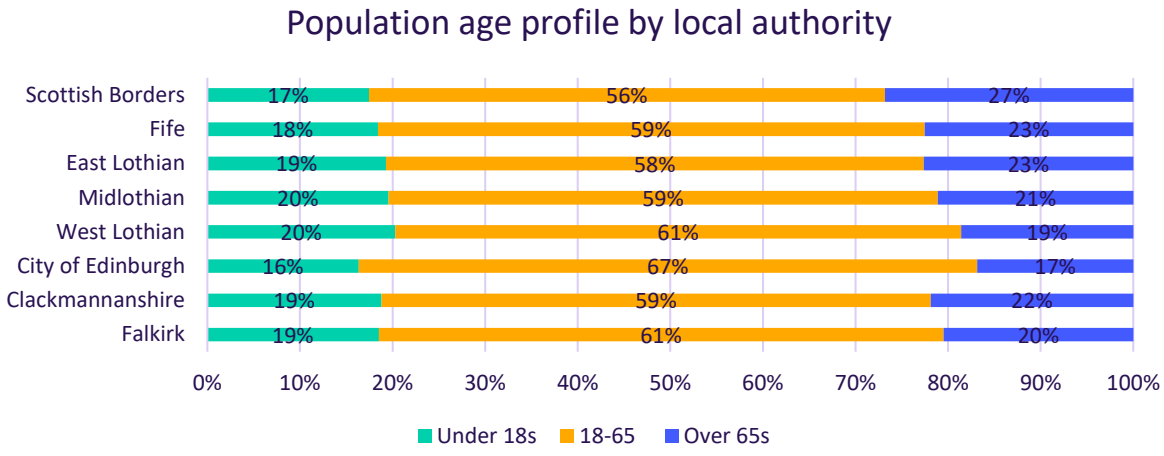


Figure 5: Population age profile by local authority

Population change across the region is uneven. National Records of Scotland projections indicate sustained growth in Edinburgh, Midlothian and East Lothian to 2032, driven by continued housing

development and inward migration.[15] Many rural areas, however, show stagnation or decline, which can exacerbate vulnerability where transport services are already limited.[16]

Midlothian is currently one of the fastest-growing areas in Scotland. The emerging Midlothian Local Development Plan 2 identifies land for approximately 8,851 new homes across the 2027–2037 plan period, reflecting a sustained period of residential expansion.[17] This scale of planned growth is expected to generate additional travel demand. Without corresponding improvements in public transport, active travel infrastructure and Transport to Health provision, increased car use may exacerbate congestion on key corridors, including those linking Midlothian to major hospitals in Edinburgh.

Socio-economic inequalities and transport poverty

Socio-economic inequalities play a significant role in shaping how people access healthcare across the SEStran region. Levels of deprivation vary widely, with concentrations in parts of Edinburgh, coastal towns, and areas of rural Fife, West Lothian and Clackmannanshire. These patterns have a direct bearing on transport needs and the options available to residents.

People living in more deprived areas are:

- ↘ More likely to have complex health needs
- ↘ Less likely to own a private car, and
- ↘ More likely to live in communities with weaker, less frequent or less reliable public transport links.

Public Health Scotland defines Transport poverty as:

> "The lack of transport options that are available, reliable, affordable, accessible or safe that allow people to meet their daily needs and achieve a reasonable quality of life."[18]

[15] National Records of Scotland (2025) Subnational Population Projections: 2022-based
[16] National Records of Scotland (2025) Council area profiles
[17] Midlothian Council (2025) Midlothian Local Development Plan 2
[18] Public Health Scotland, 2024, Transport Poverty Briefing

A key driver of transport poverty is the dominance of the private car within the transport system. Where household car access is low, residents have fewer alternatives when public transport is limited, indirect or expensive. Deprivation and transport poverty therefore tend to reinforce one another.

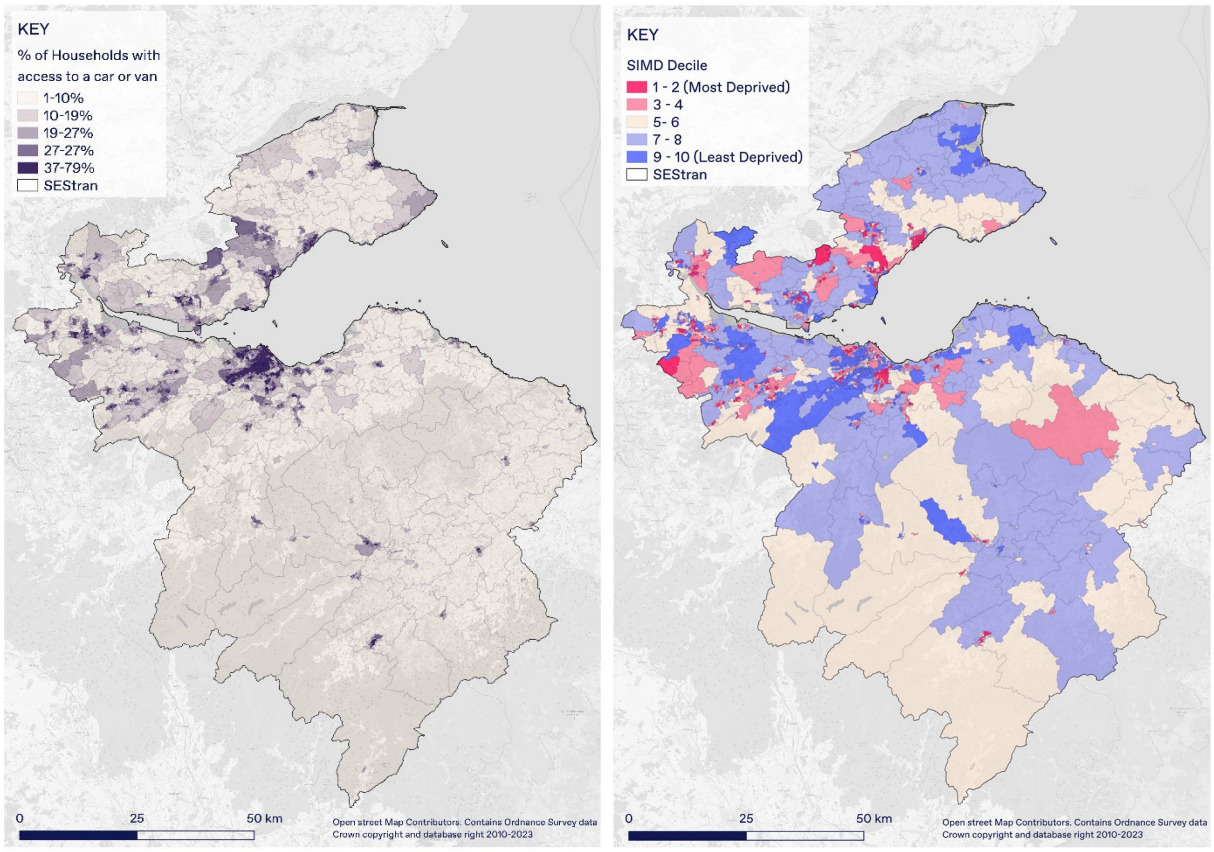


Figure 6: Deprivation and car access across the SEStran region

Figure 6 illustrates these relationships. Areas with higher deprivation also show the highest proportions of households without access to a private car. This overlap identifies communities where reliance on public or community transport is greatest and where long or complex journeys to healthcare are most likely to be experienced as a barrier.

Figure 7 strengthens the disparity by showing that households in the most deprived deciles are significantly more likely to have no access to a car than those in more affluent areas.

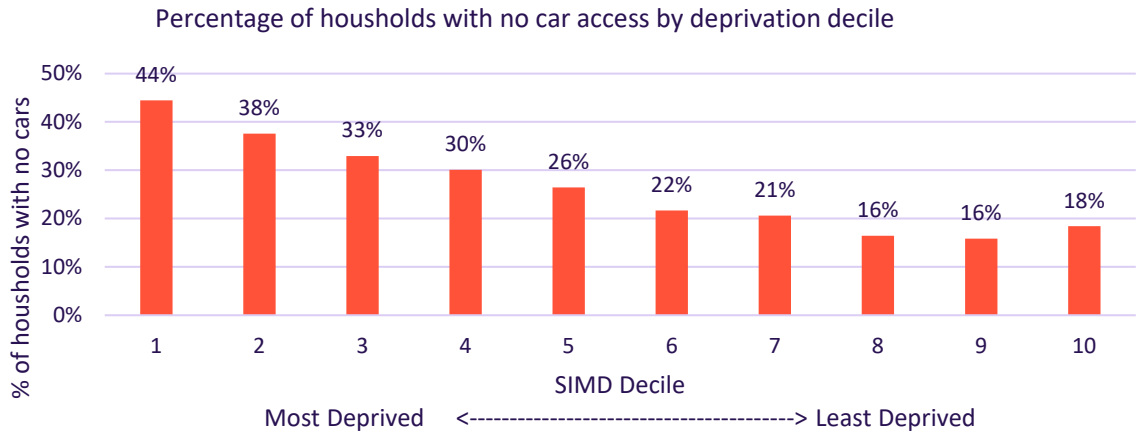


Figure 7: Car access by deprivation decile

As a result, residents in the most deprived communities are disproportionately reliant on public transport and therefore more exposed to long travel times, limited-service availability and indirect routes to both primary and hospital-based care. For those with chronic conditions, mobility impairments or frequent appointments, these barriers can lead to missed or delayed care and increased pressure on informal support networks.

Taken together, these findings highlight where transport-related disadvantage is most concentrated and provide a strong foundation for identifying the communities where improvements in Transport to Health provision will have the greatest impact.

Transport network characteristics and access to primary care

Public transport and driving travel times

Access to primary care (community-based, first-contact NHS services) across the SEStran region is shaped by the structure of the transport network and the significant differences in journey times between travel modes. Travel-time modelling shows clear and consistent disparities between public transport and driving when accessing GP surgeries.

Across most of the region, travelling to a GP by public transport takes between two and three times longer than travelling by car. This pattern is evident in urban, semi-rural and rural settings, reflecting the indirect nature of many bus routes, interchange requirements and variable service frequencies. The maps in figure 8 illustrate the distribution of public transport journey times to GP surgeries, compared with the equivalent driving times.

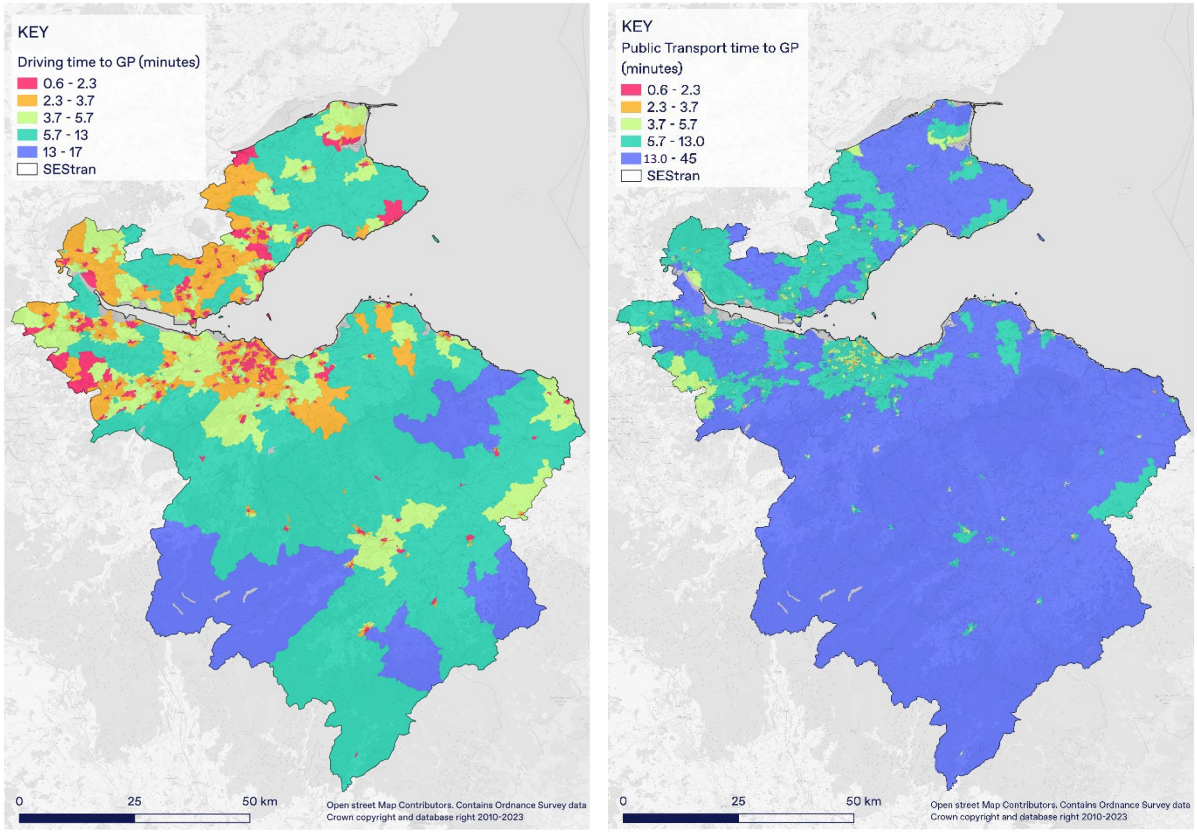


Figure 8: Public transport and driving travel times to GP surgeries across the SEStran region

Figure 9 reinforces this pattern, showing average travel times to GP surgeries by local authority and highlighting substantial differences between car and public transport journey times.

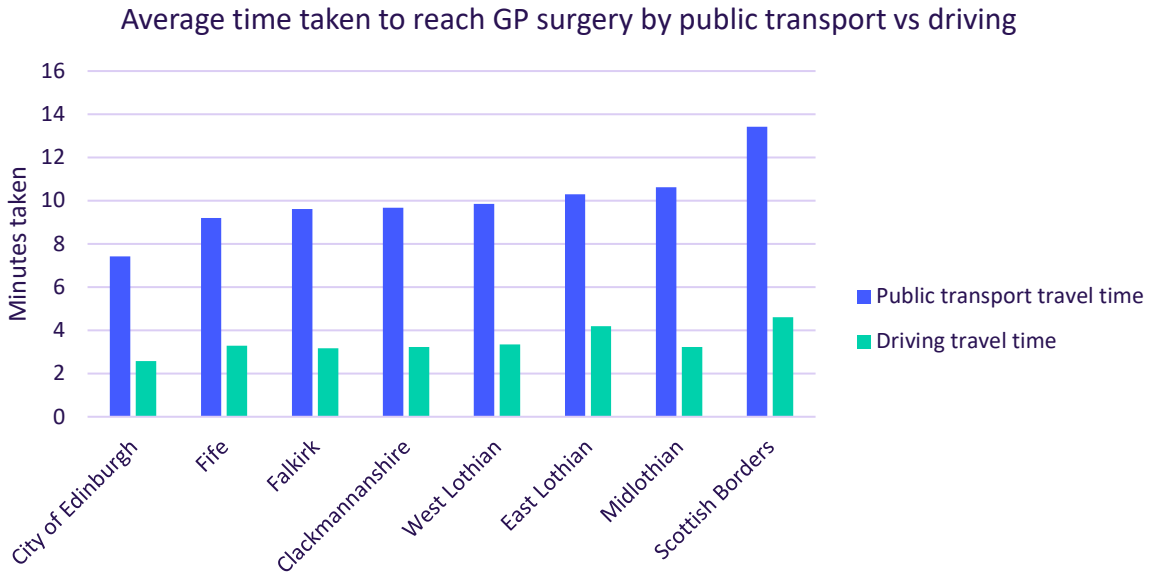


Figure 9: Average journey time to GP surgery by mode and local authority

Deprivation and travel times

The relationship between travel times and deprivation is shown in Figure 10. Modelled public transport journey times do not vary substantially across deprivation deciles, yet residents in the most deprived areas are significantly less likely to own a car. As a result, they cannot avoid relying on longer and often indirect public transport journeys to reach healthcare appointments.

For people with long-term conditions or regular outpatient needs, these extended journey times can present a material barrier to consistent healthcare access.

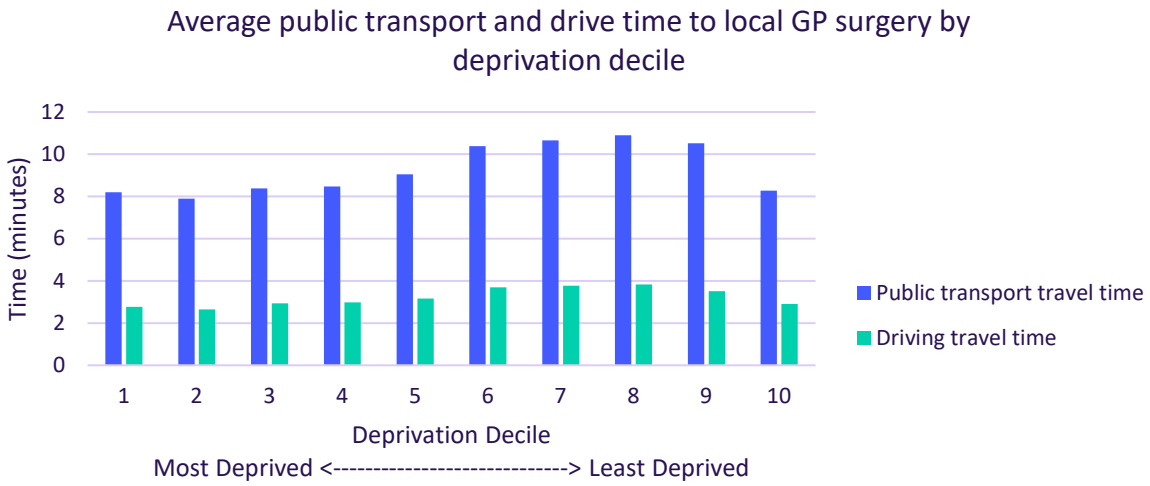


Figure 10: Average public transport and driving time to GP surgery by deprivation decile

Rurality and travel times

Rurality is one of the strongest determinants of long or complex journeys to primary care. Figure 11 shows that remote rural areas experience the highest average public transport journey times to GP surgeries, averaging around 24 minutes. By contrast, large urban areas have average travel times of 7.5 minutes, illustrating the substantial difference in accessibility between settlement types.

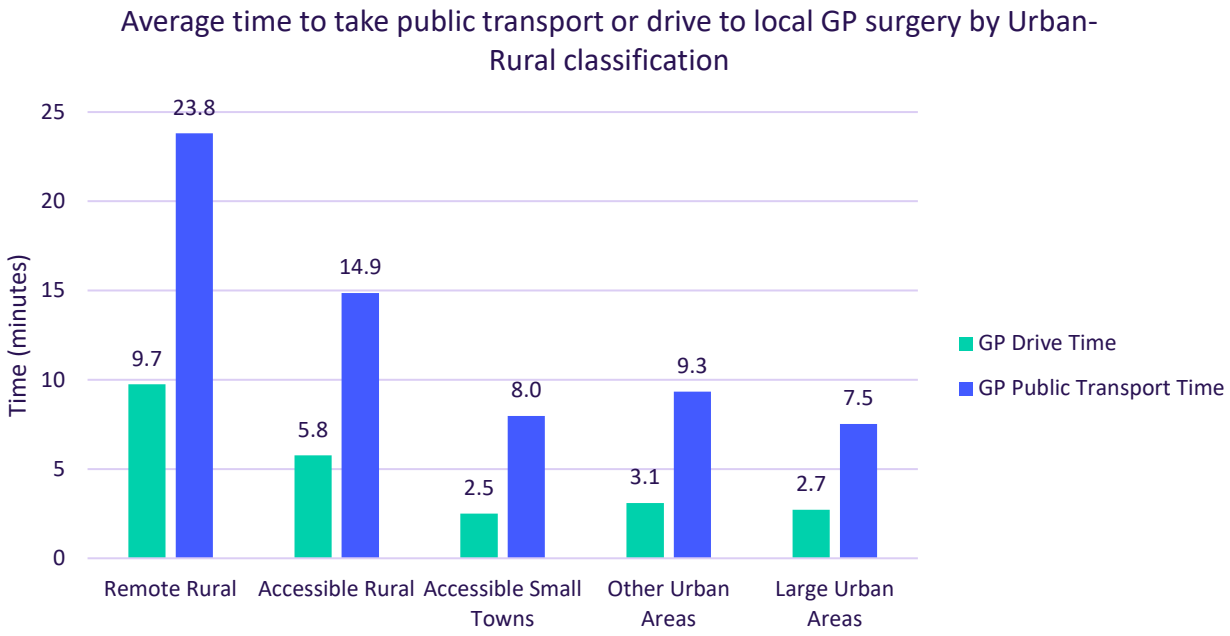


Figure 11: Average journey time to GP surgery by urban–rural classification

Accessible rural areas and small-town settings also experience longer average journey times than urban centres, reflecting more dispersed settlements, reduced service frequencies and longer distances to healthcare sites.

The infographic below highlights this disparity clearly: a typical public transport journey to a GP in remote rural areas takes more than three times longer than in large urban areas.

Access to secondary and tertiary care

Secondary and tertiary healthcare services (specialist hospital services and highly specialised care, respectively) are more centralised across the SEStran region and typically require longer travel distances than primary care. These services are located in a smaller number of acute hospitals, meaning that many residents - particularly those in Clackmannanshire, the Scottish Borders, rural Fife and East Lothian - must travel outside their immediate community to reach treatment.

Figure 12 shows the distribution of data zones by Local Authority which fit into various journey time brackets. The list of hospitals including in modelling were those considered as key NHS Scotland Accident and Emergency Sites, with sites comprised of Emergency Departments and Minor Injuries Units (MIU). Transport Scotland has used TRACC modelling software to estimate the journey times to key hospitals. This model demonstrates longer journey times to hospitals than primary care services like GPs.

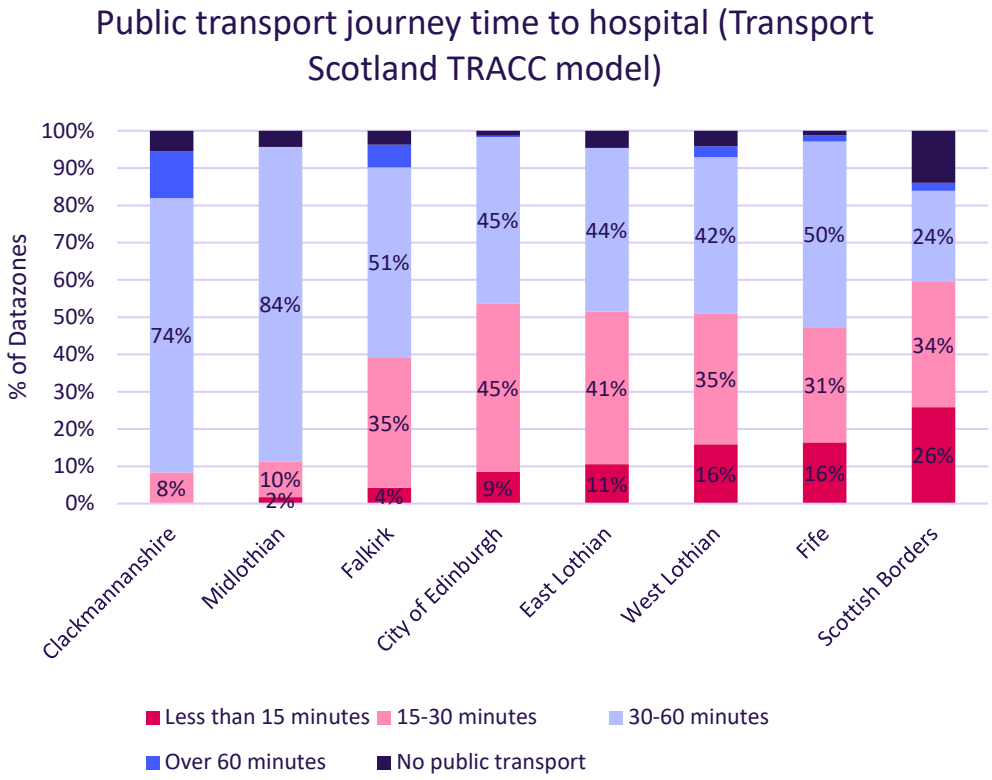


Figure 12: Public transport journey time to hospital (Transport Scotland TRACC model)[19]

[19] Transport Scotland, 2022, Journey Time Estimates Monitoring And Evaluation 2019 Baseline Report May 2022 National Transport Strategy NTS2

Public transport journey times to hospital are substantially longer than those to GP surgeries due to the nature of the spatial distribution of healthcare services. Across the region, journeys to hospital by public transport take more than three times as long on average as those to GP surgeries.

9 minutes Average journey time to GP surgery

31 minutes Average journey time to major hospital

In Clackmannanshire, this disparity is particularly pronounced: modelled travel times indicate that public transport journeys to hospital are 4.6 times longer than equivalent journeys to a GP. This reflects the absence of a major acute hospital within the local authority boundary, with residents travelling to Forth Valley Royal Hospital or Stirling Community Hospital for secondary care.

These differences highlight the value of shifting some routine outpatient activity into more local settings, where appropriate, and improving coordination between transport provision and hospital scheduling.

Origin-destination patterns for hospital access

Origin–destination modelling provides further insight into how residents across the SEStran region travel to major hospitals. Figure 13 shows modelled routes and travel times between local communities and hospital sites, illustrating the wide catchment areas served by hospitals in Edinburgh, Larbert, Kirkcaldy and Melrose.

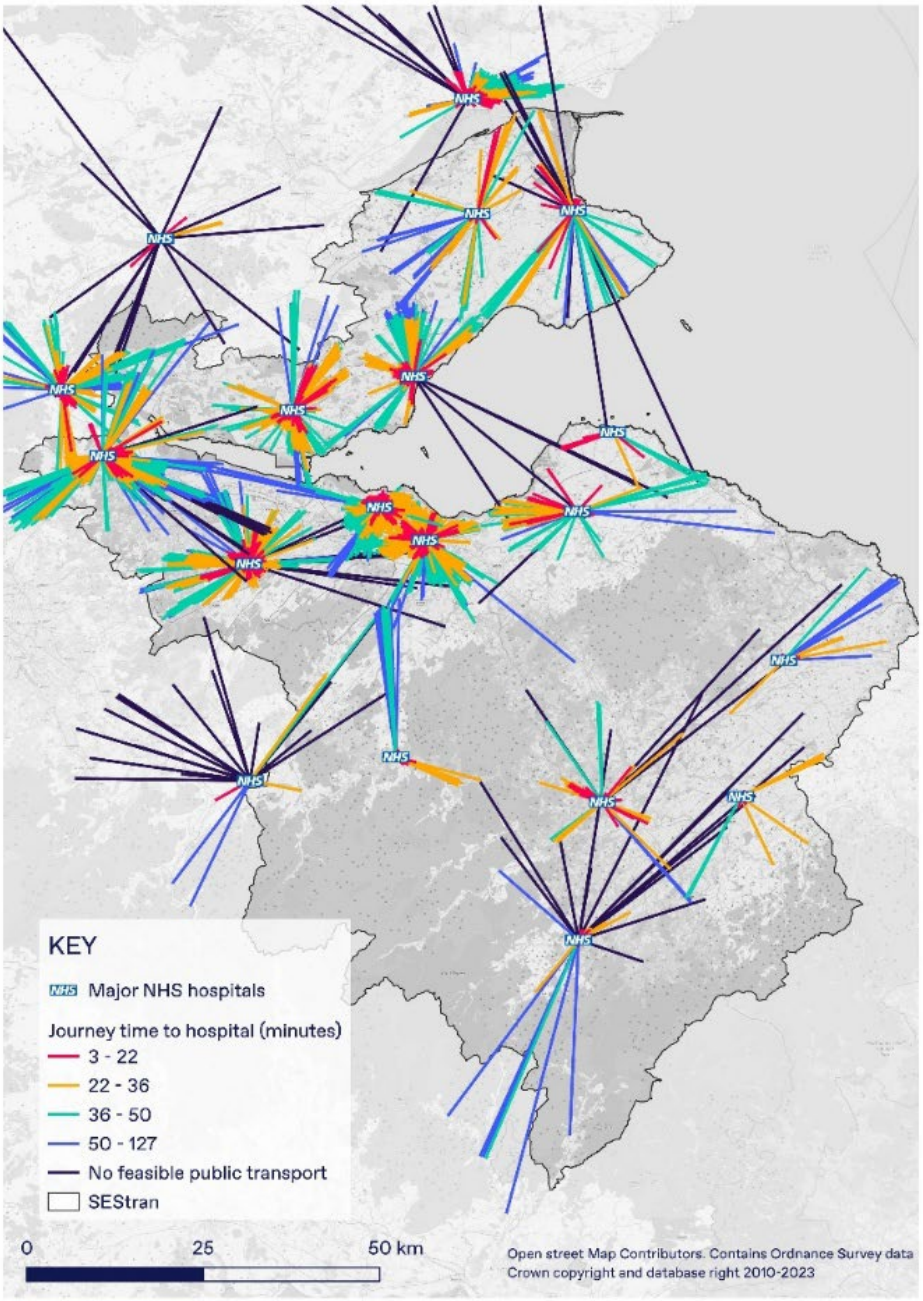


Figure 13: Origin–destination patterns for public transport travel to major hospitals

Figure 14 presents an aggregated view of public transport travel times to the nearest major hospital.

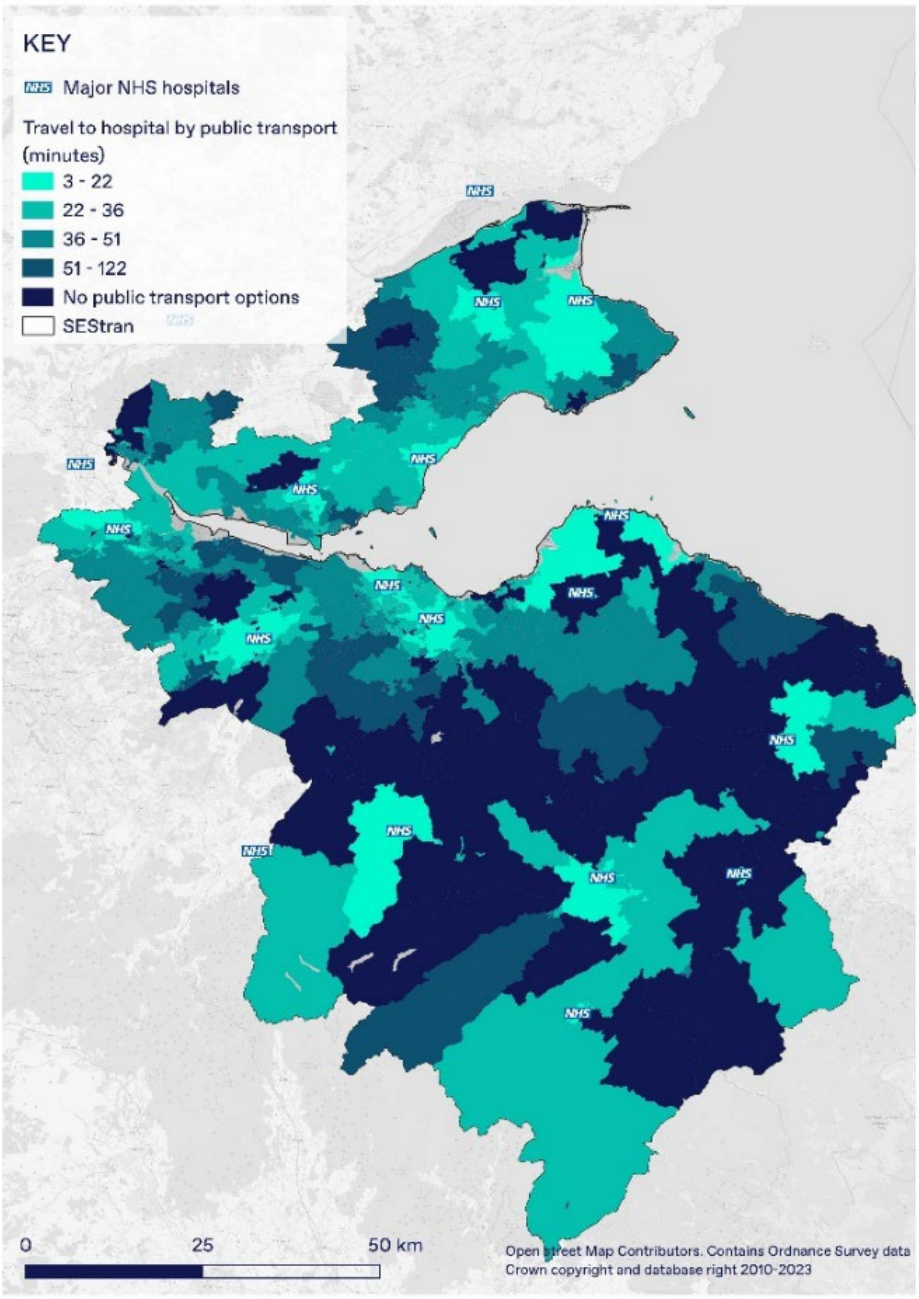


Figure 14: Public transport travel time to nearest major hospital

Two key findings emerge:

- Large parts of Clackmannanshire, the Scottish Borders and rural Fife experience hospital travel times exceeding 50 minutes by public transport.
- Several areas have no feasible public transport connection to a major hospital within a reasonable travel time.

These spatial patterns underline the need for targeted interventions to reduce travel burdens for communities with the longest and most complex hospital journeys.

Public consultation summary

An online public consultation survey was undertaken between 15th October 2025 and 16th November 2025 to gather insight into how people across the SEStran region travel to healthcare appointments, the challenges they face, and how these vary by geography, type of care and personal circumstances.

The survey provides essential lived-experience evidence that complements the desk-based analysis in the previous section and directly informs the Problems, Opportunities, Issues and Constraints (POIC) assessment.

This section summarises who responded to the survey, how they travel, and the barriers they reported, where they live, how they currently travel to healthcare, and the main challenges they reported. This section builds on this by examining the results in more depth at Health Board level.

A full response data set has been provided in Appendix A.

Survey participation

Survey reach

A total of 1,512 people completed the survey, providing rich qualitative and quantitative insights across all eight Local Authority areas in the SEStran region.

Postcode completeness

Respondents were asked to provide a sector-level (four–five digit) postcode to support geographic assignment. Of the 1,512 responses:

- 1,340 respondents (88%) provided a district-level postcode (e.g. TD2)
- 866 respondents (59%) provided a sector-level postcode (e.g. TD2 1)
- Only a small proportion of respondents did not provide sufficient information for geographic mapping.

This high level of completeness enables accurate grouping by Local Authority and Health Board and supports reliable spatial analysis. Figure 15 illustrates how respondents are distributed across the region. The left-hand map shows response density at postcode district level, while the right-hand map presents finer-grained patterns by postcode sector.

Together, these maps demonstrate broad geographic coverage, including strong participation across East Lothian, Fife, the Scottish Borders and Midlothian, and meaningful representation in both rural and urban areas.

This provides a robust basis for interpreting the geographic patterns discussed later in this section.

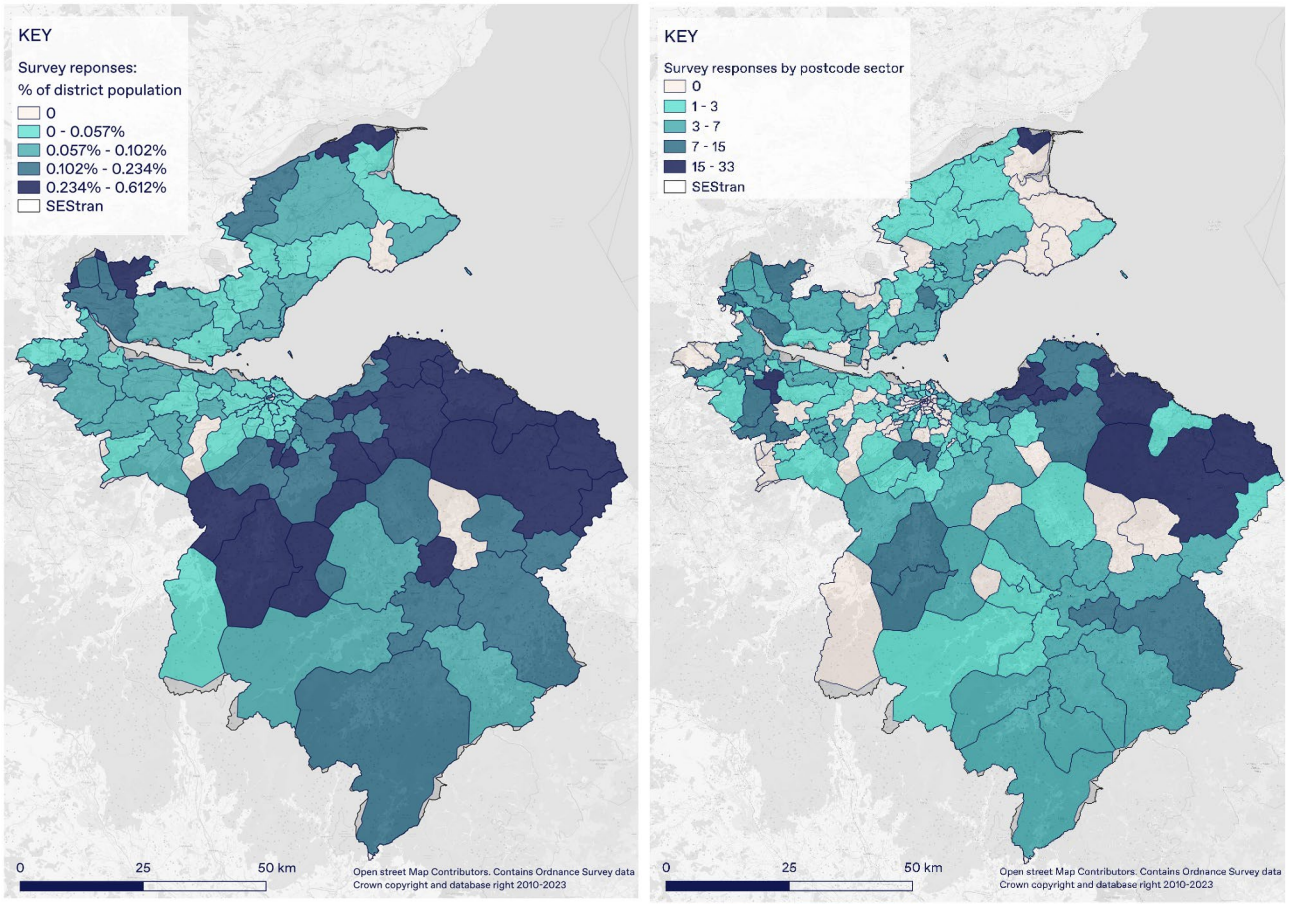


Figure 15 Density of survey responses by postcode district (left) and total responses by postcode sector (right)

Geographic distribution of responses

Responses by Local Authority

A broad spread of responses was received across the region. As illustrated in Figure 16, the highest numbers of responses came from East Lothian, Fife, and the Scottish Borders, reflecting strong participation in areas where Transport to Health is a significant local concern. Only nine responses originated from outside the SEStran region. Although Clackmannanshire has a smaller population base, it contributed a meaningful volume of responses, enabling locally relevant insight.

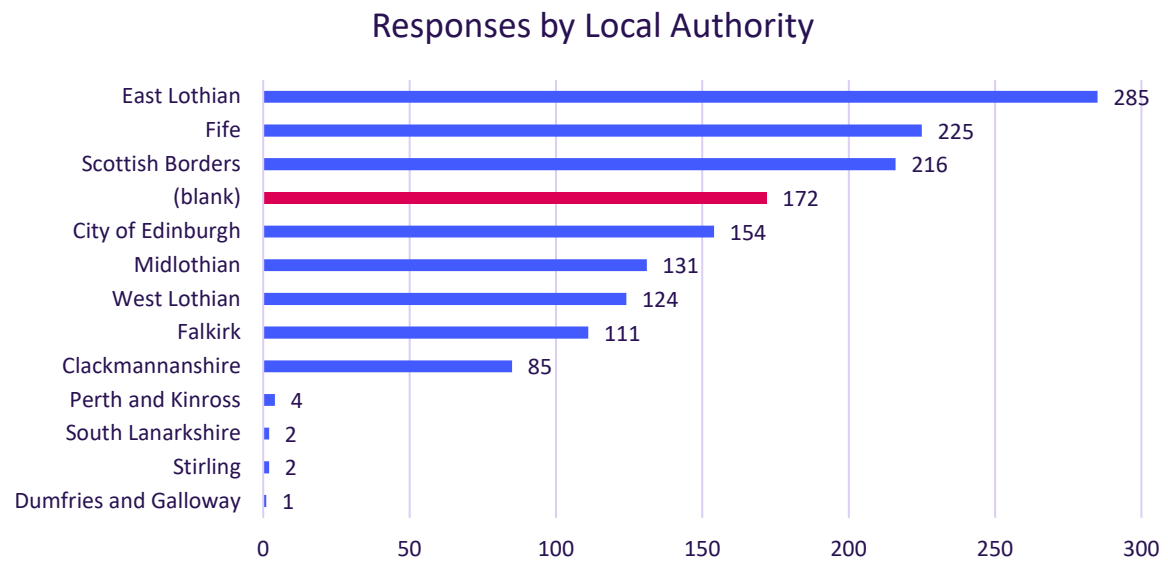


Figure 16: Responses by Local Authority

Responses by Health Board

When mapped to Health Board areas (Figure 17), the distribution broadly mirrors population patterns. NHS Lothian accounts for the largest share of responses, consistent with its significantly higher population density. Substantial numbers were also received from NHS Fife, NHS Borders and NHS Forth Valley, supporting Health Board–level analysis in the next section.

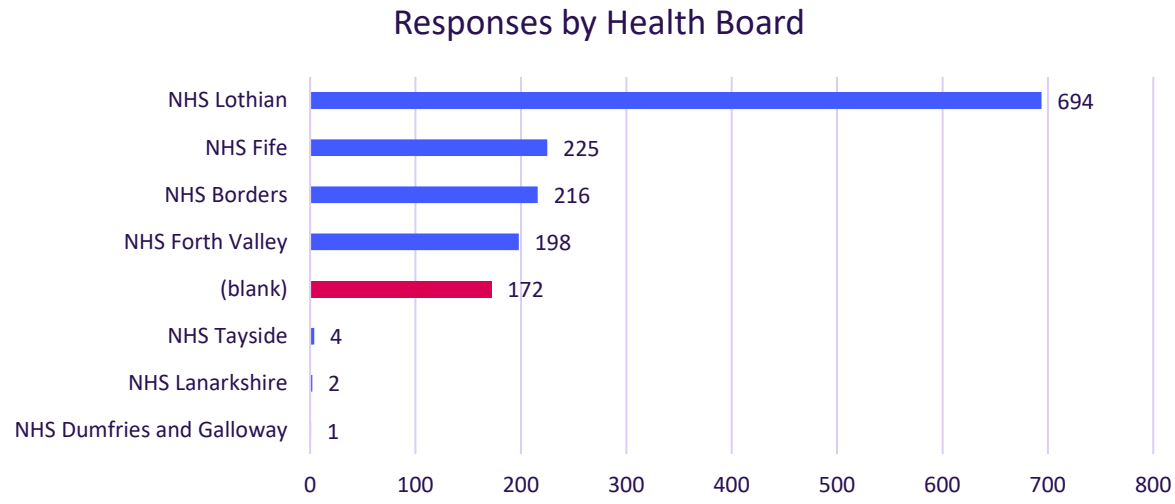


Figure 17: Responses by Health Board

Respondent characteristics

Respondents represented a wide range of travel needs and circumstances. Figure 18 summarises relevant characteristics of survey respondents, it demonstrates that respondents to our survey were marginally more likely to have access to a car or van and significantly more likely to be a woman, over 60 years old, have a long-term health condition/disability or provide unpaid care. This mixture of characteristics shows that respondents to our survey belong to groups more concerned with being able to easily travel to healthcare services than the average SEStran resident.

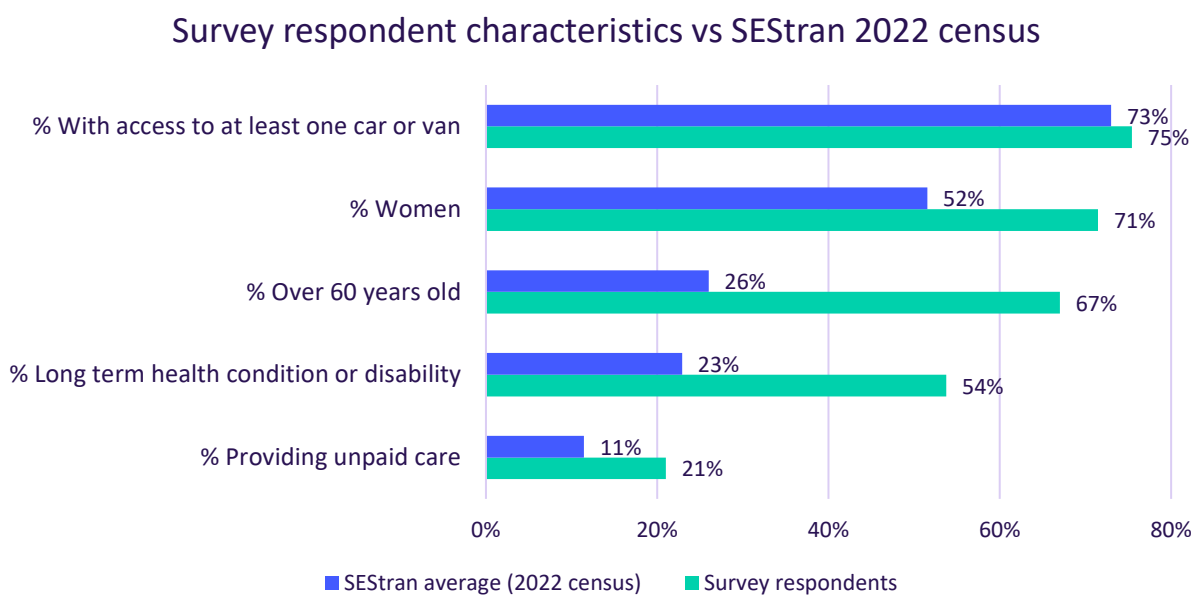


Figure 18: Survey respondent characteristics vs SEStran average via 2022 Census[20] [21] [22]

An additional characteristic to note is that our survey found 73% of those acting as a carer to someone when travelling to appointments are women. This coheres with the Carers Census 2023/24 which also found that 73% of unpaid carers in the SEStran area are women.[23]

Figure 19 demonstrates how survey respondents are heavily weighted to be older and are predominantly women.

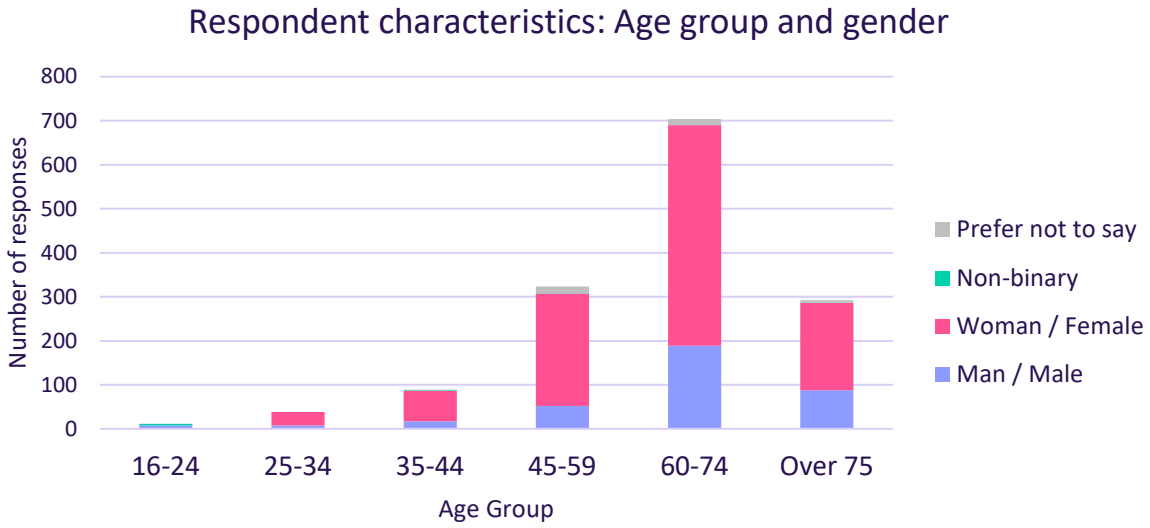


Figure 19: Age and gender distribution of survey respondents

Figure 20 displays the 55% of respondents who provided income data. The 45% who did not provide data makes this data an incomplete view of our respondents but gives an indication that the median income of respondents may be between £20,000 - £30,000.

[20] Scottish Government, 2024, Scotland's Census 2022 - Health, disability and unpaid care
[21] National Records of Scotland, 2025, Scotland's Census 2022 - UV102a - Age by sex
[22] National Records of Scotland, 2025, Census 2022 estimates for Car or van availability
[23] Scottish Government, 2024, Carers Census, Scotland, 2023-24

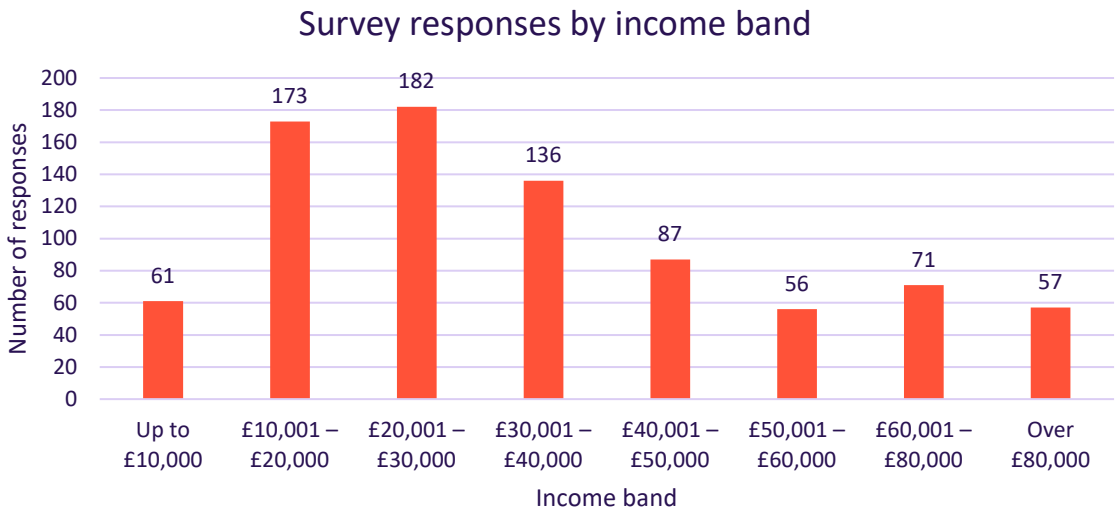


Figure 20: Number of survey responses by income band

From the survey, 90% of respondents provided data on ethnicity. The majority of the responses from white Scottish (80%), other white British (17%) other whites (2%). Less than 1% of responses came from other groups. This demonstrates that this survey is missing the perspectives of the 4% of SEStran population who are Asian, Asian Scottish or Asian British, the 2% who are African, and the 2% who are from other ethnic groups.

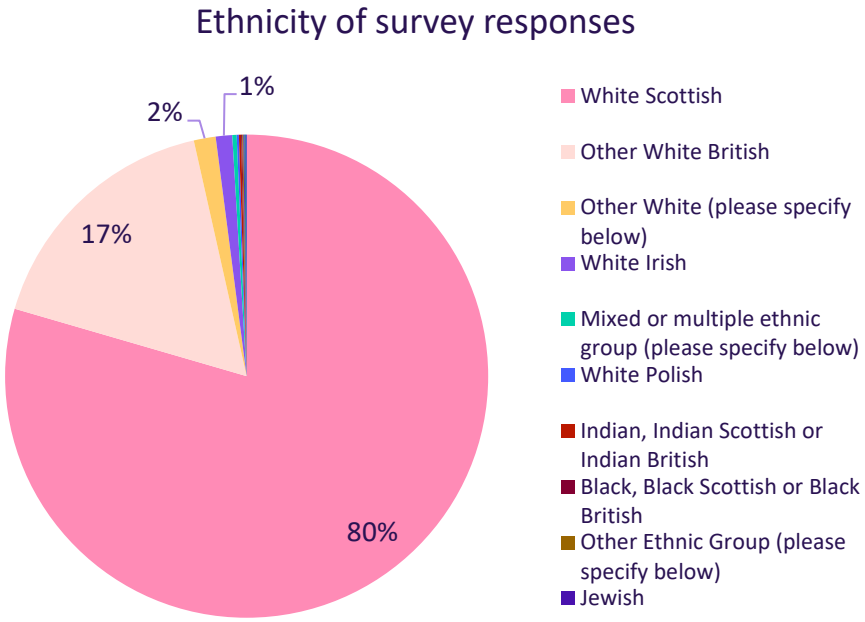


Figure 21: Ethnicity of survey responses

These characteristics help explain variations in the types of transport challenges described across the region.

How respondents travel to healthcare

Respondents used a range of modes to reach healthcare, with mode choice strongly shaped by geography, car access and type of care.

- Car travel (driving or as a passenger) was the most commonly used mode across the region.
- Bus was the dominant public transport mode across the geography types.
- Walking and cycling were most common for nearby GP and pharmacy visits.
- Taxis and community transport were essential for some, particularly those with mobility impairments or living in rural areas.
- Rail was used mainly for longer-distance journeys to specialist care.

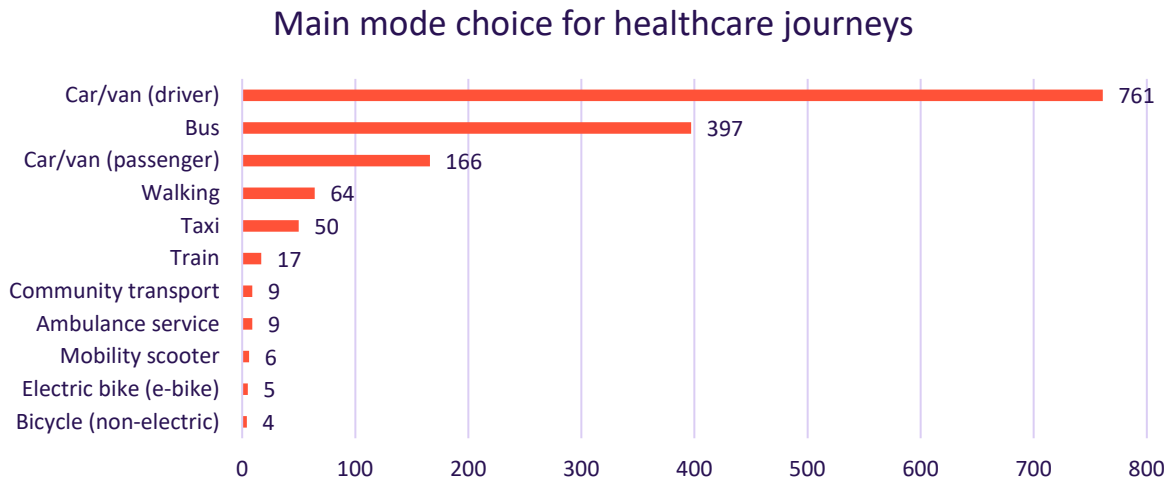


Figure 22: Main mode choice for healthcare journeys

Figure 22 displays the main mode choice for healthcare journeys found by our survey compared to general main mode choice in the SEStran area as reported by the Scottish Household Survey. Healthcare journeys are three times more likely to be by bus and six times less likely to be by walking.

Healthcare journeys often involve multiple stages, including walking, which are not captured by main mode choice alone. The older age profile of survey respondents also partly explains lower levels of active travel. Even allowing for these factors, active travel remains far less common for healthcare journeys than for everyday trips, reflecting longer travel distances and the limited walkable accessibility of many secondary healthcare sites.

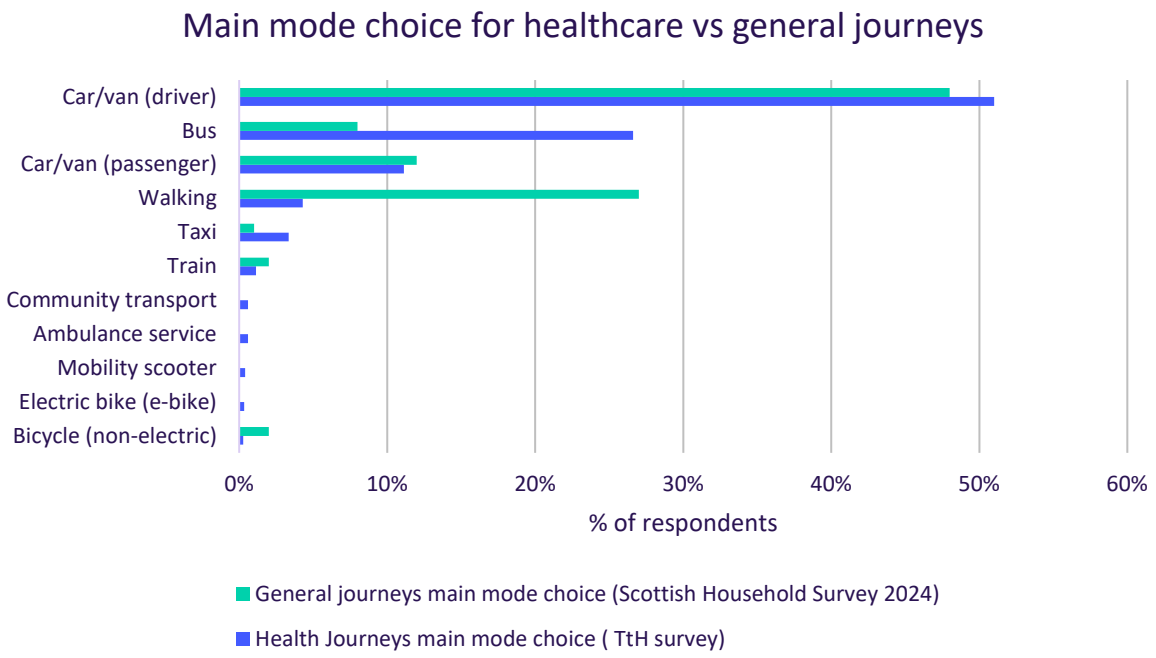


Figure 23: Main mode choice for healthcare journeys versus general journey choice via the Scottish Household Survey [24]

Respondents without access to a car often described long or complex journeys involving multiple interchanges.

Missed or delayed healthcare appointments due to transport

Across the SEStran region, a substantial proportion of respondents reported missing or delaying healthcare appointments due to transport-related issues. Around one third of respondents in each Health Board area indicated that transport had prevented them from attending appointments as planned, rising to over 40% in NHS Fife.

While transport is not the sole cause of non-attendance, respondents consistently linked missed or delayed appointments (Figure 24) to unreliable or infrequent public transport, traffic congestion, accessibility and mobility challenges, and difficulties aligning appointment times with available services. These impacts were most pronounced for hospital outpatient and specialist appointments, where journeys are longer, more complex and more sensitive to delays.

[24] Transport Scotland, 2025, Transport and Travel in Scotland 2024 - SHS

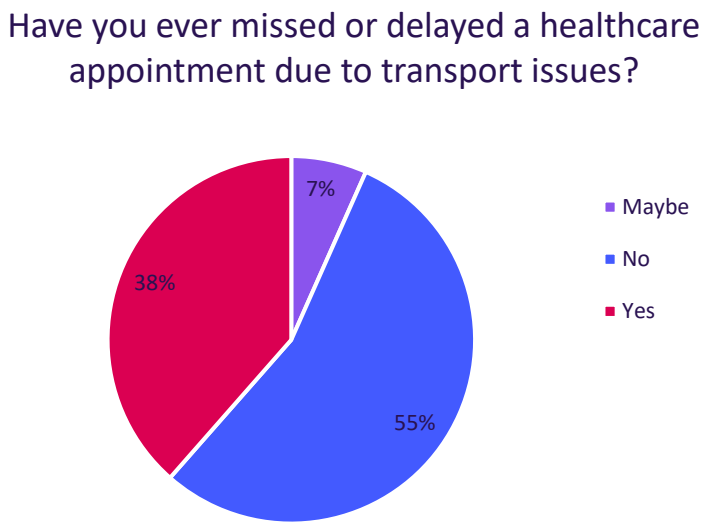


Figure 24: Proportion of respondents who have missed or delayed a healthcare appointment due to transport issues

Main challenges reported by respondents

Respondents highlighted several recurring challenges that affected their ability to attend healthcare appointments reliably, affordably and comfortably.

Long, indirect and complex journeys

Many respondents described journeys involving multiple buses, long walking distances or indirect routes, particularly for hospital appointments.

> "I have to take two buses and then walk for 15 minutes."

Infrequent or poorly timed services

Early-morning, late-afternoon and evening appointments were difficult to reach using public transport. Weekend services were limited in several areas.

> "There's no Sunday service, so I have to miss weekend appointments."

Cost barriers

For those without a car, especially people attending regular treatment (such as oncology, dialysis or physiotherapy), the cumulative cost of transport was a significant burden.

Accessibility barriers

Those with limited mobility reported challenges such as:

- Long walking distances to stops
- Poorly maintained or inaccessible bus stops
- Difficulty boarding or alighting buses

- Steep gradients or uneven pavements

Parking pressures

Even those travelling by car reported difficulties finding parking at major hospitals, contributing to stress and late arrivals.

> "The bus doesn't line up with my clinic time - I always arrive far too early or late."

Differences by type of healthcare appointment

Transport challenges varied depending on the purpose of the appointment:

Primary care

- Generally easier to reach due to community-based location of GP practices.
- Shorter journey times across all Health Board areas, particularly for those living in urban and semi-urban settings.
- Challenges increased where GP practices had merged or relocated more typically seen in rural and semi-rural areas.
- Shorter journey times across Health Board areas compared to secondary care (does not exceed 60 minutes).

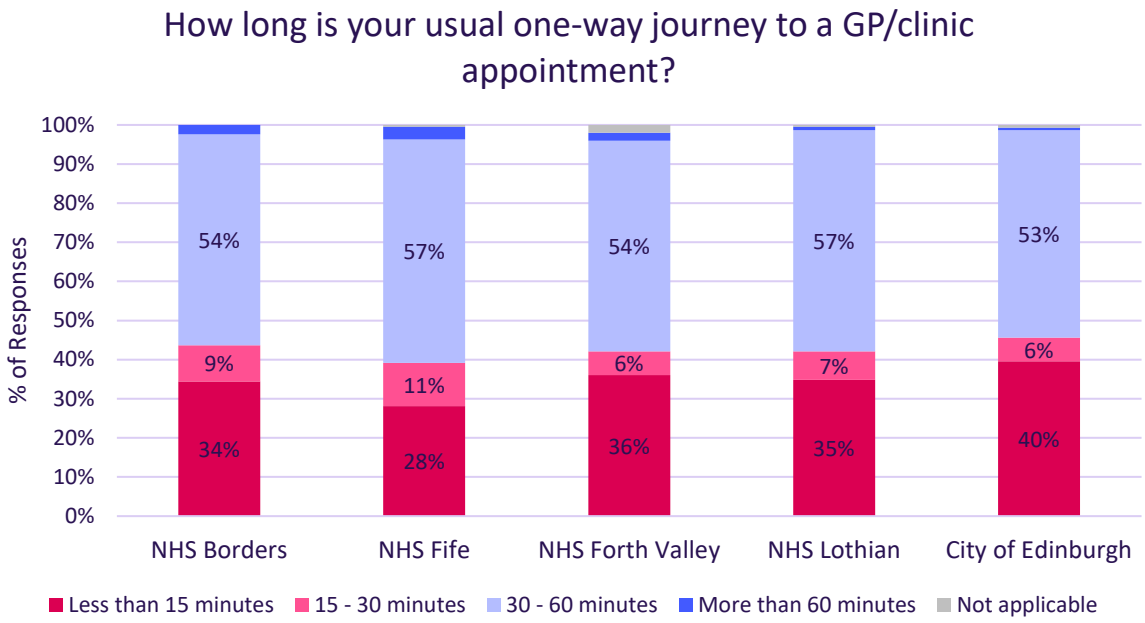


Figure 25: Survey response by Health Board - Length of journey time to GP/clinic appointment

Secondary care

- Frequently the most challenging journeys across all four Health Boards.
- Longer distances, fewer direct routes and greater reliance on interchange, particularly for public transport users.

- Longer journey times across Health Board areas (typically over 30 minutes, often over 60 minutes).
- Regular outpatient and specialist appointments compound the impact of long and complex journeys, increasing fatigue, stress and risk of non-attendance.

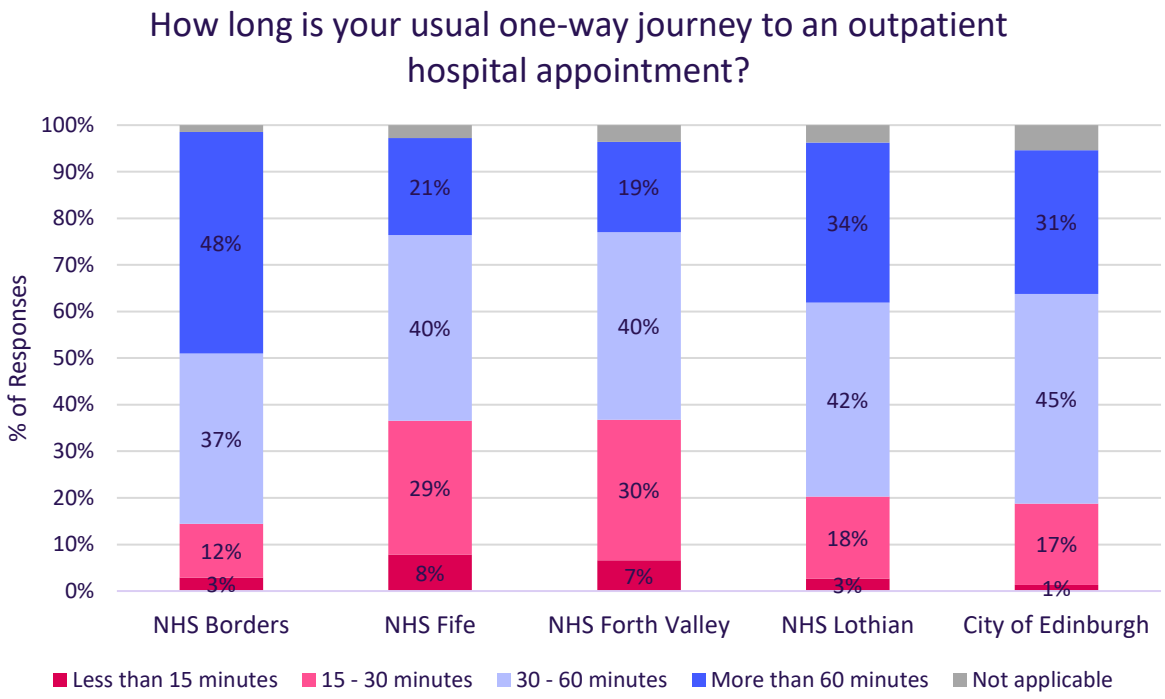


Figure 26: Survey response by Health Board - Journey time to Hospital Outpatient appointment

Tertiary care / specialist services

- Regular travel for cancer care, renal appointments or diagnostics was described as tiring, stressful and expensive

Mental health services

- Some respondents cited anxiety linked to long or uncertain journeys, unreliable services or unfamiliar environments

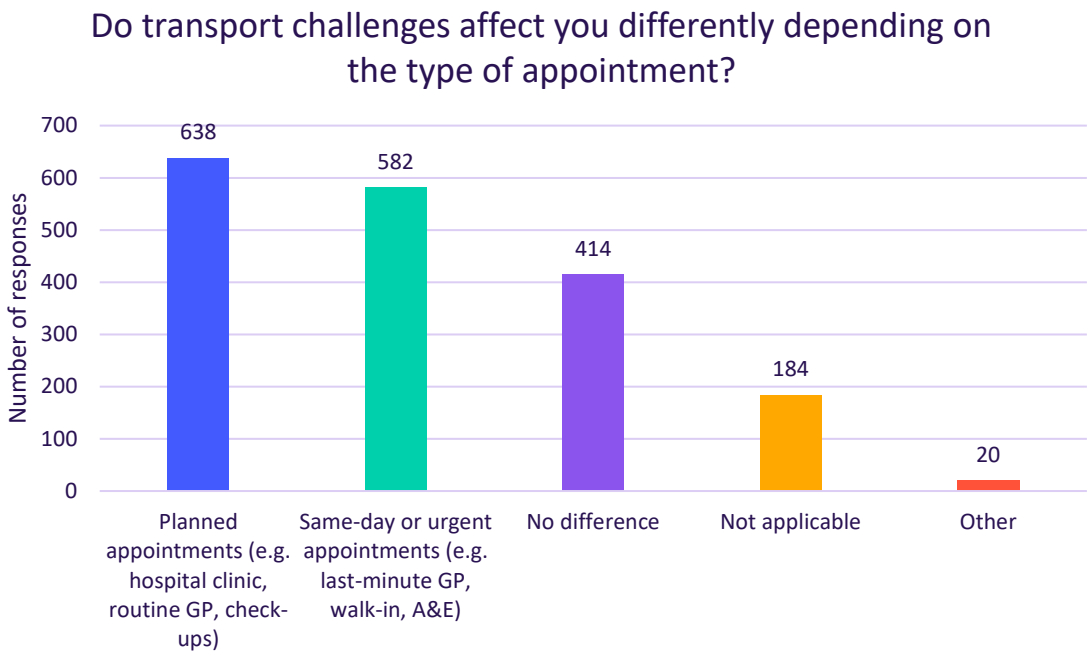


Figure 27: Responses Survey question: Do transport challenges affect you differently depending on the type of appointment?

"Very difficult to get to hospital appointments in Edinburgh from North Berwick. No direct transport"

Key themes emerging from the survey

Across geographies and demographic groups, several strong and consistent themes emerged:

- People without access to a car face the greatest barriers and the longest, most complex journeys.
- Transport disadvantage aligns strongly with rurality and deprivation.
- Many journeys require multiple modes or long interchanges, which increase time, cost and uncertainty.
- Disabled people and those with long-term conditions face disproportionate accessibility challenges.
- Appointment timing is a major barrier, particularly when slots fall outside regular public transport timetables and frequencies.
- Carers have distinct needs related to accompanying patients.
- Centralisation of services at the likes of hospitals instead of GPs practices makes attending more difficult. These themes align closely with the desk-based evidence and help pinpoint the most affected communities.

Health Board insights

NHS Lothian – evidence summary

Area overview

NHS Lothian covers the City of Edinburgh, East Lothian, Midlothian and West Lothian. It is the most populous Health Board in the SEStran region and contains a mix of distinct settlement types and healthcare facilities, including:

- Dense urban centres (Edinburgh)
- Rapidly growing commuter towns (Midlothian, West Lothian, East Lothian)
- Coastal communities and rural settlements
- Major regional hospitals including the Royal Infirmary of Edinburgh (RIE), Western General Hospital (WGH), St John's Hospital (Livingston), and East Lothian Community Hospital

These contrasting geographies shape the transport needs of the population. Edinburgh benefits from extensive public transport coverage, whereas many residents of Midlothian, West Lothian and East Lothian rely on longer or multi-stage public transport journeys to reach major hospitals, particularly those located in the capital.

Figure 28 illustrates this geography, including the distribution of settlements, key A-roads and motorways, and rail corridors such as the A1 corridor, Borders Railway, Edinburgh–Glasgow line and North Berwick line. Connectivity is strongest along these corridors, while parts of Midlothian, East Lothian and western West Lothian experience weaker public transport provision.

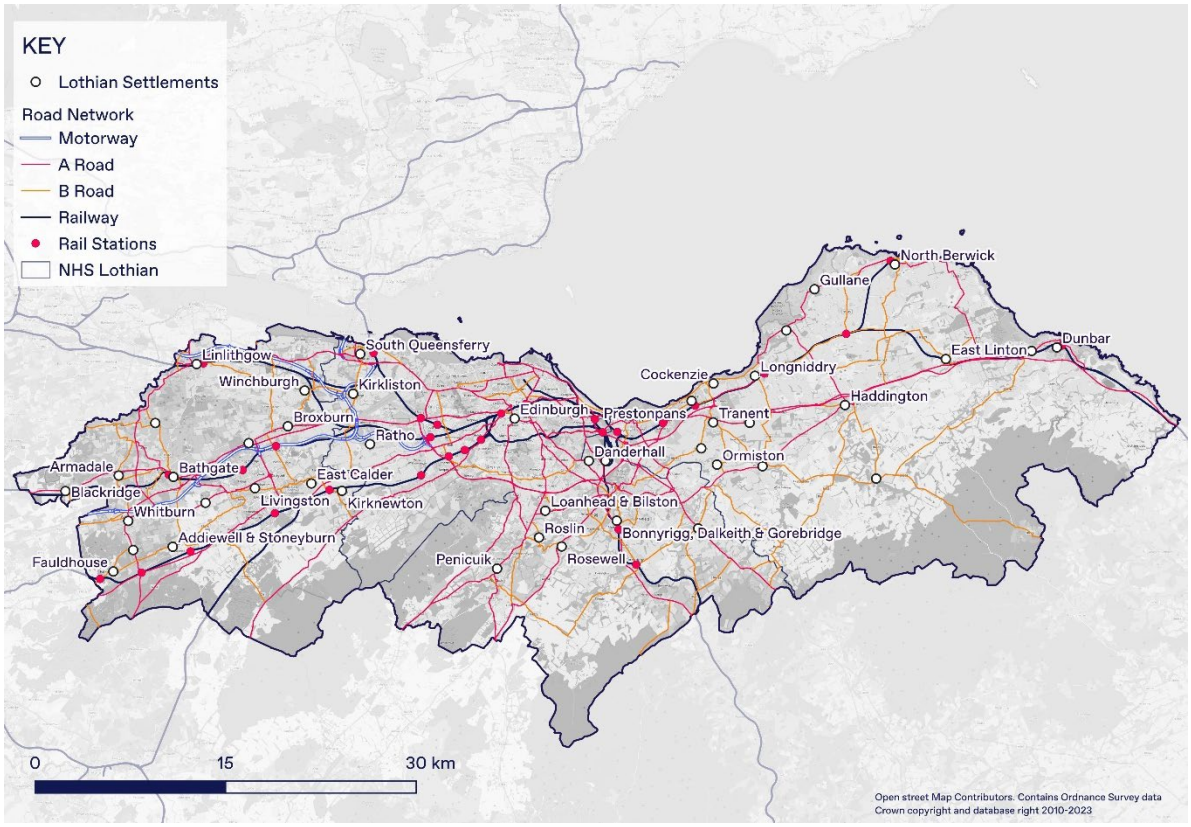


Figure 28: NHS Lothian Settlements and Transport Network

Primary healthcare services are broadly aligned with settlement centres, but Figure 29 shows that secondary and specialist services are much more centralised. The concentration of acute hospitals in Edinburgh means that significant cross-boundary travel occurs, including travel from Livingston, Haddington, Penicuik, Tranent and coastal East Lothian into the city for diagnostics, outpatient care and specialist treatment.

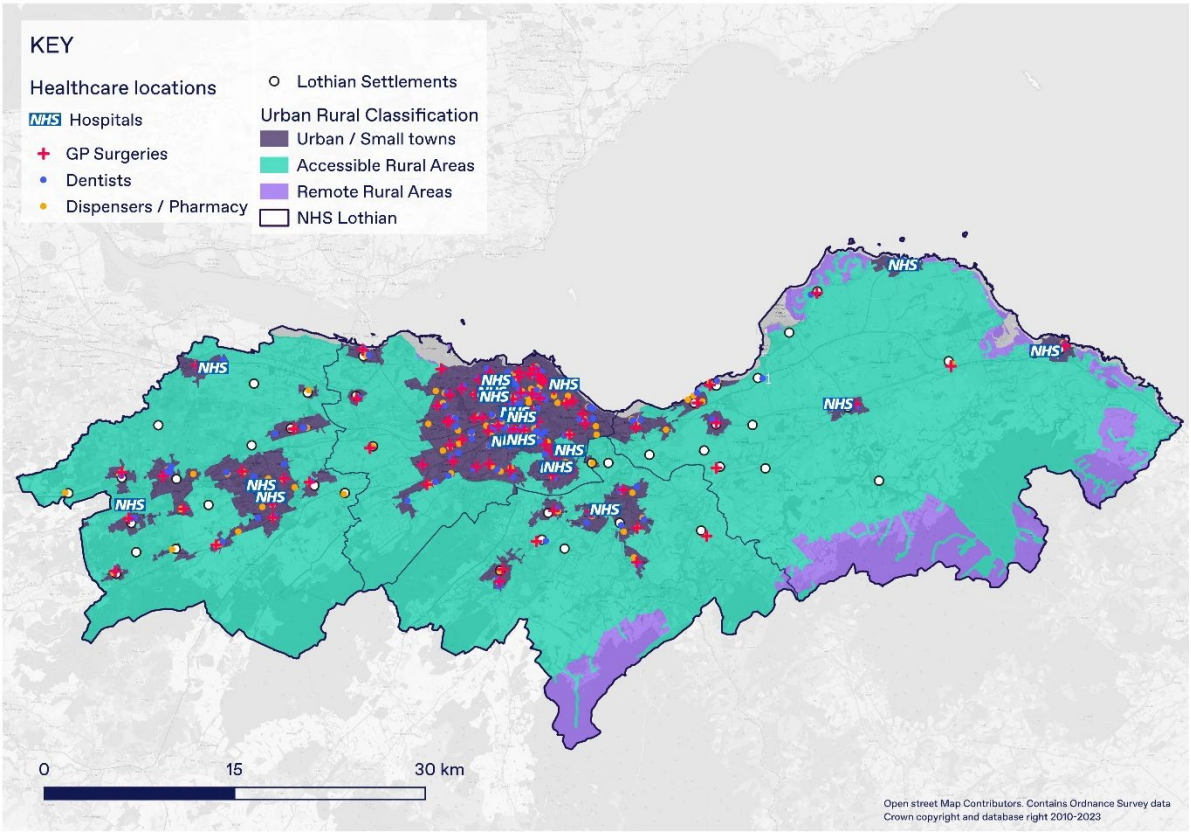


Figure 29: All healthcare locations in NHS Lothian against Settlements and Urban-Rural Classification

Travel times to major hospitals vary substantially. Figure 30 shows modelled public transport travel times and interchange requirements to the Royal Infirmary of Edinburgh from key towns across the Lothian area. Many residents face journeys of 60–90 minutes or more by public transport, often requiring two buses or a bus-rail combination. These patterns align closely with public consultation findings, which frequently highlighted indirect routes, limited direct services and long travel times.

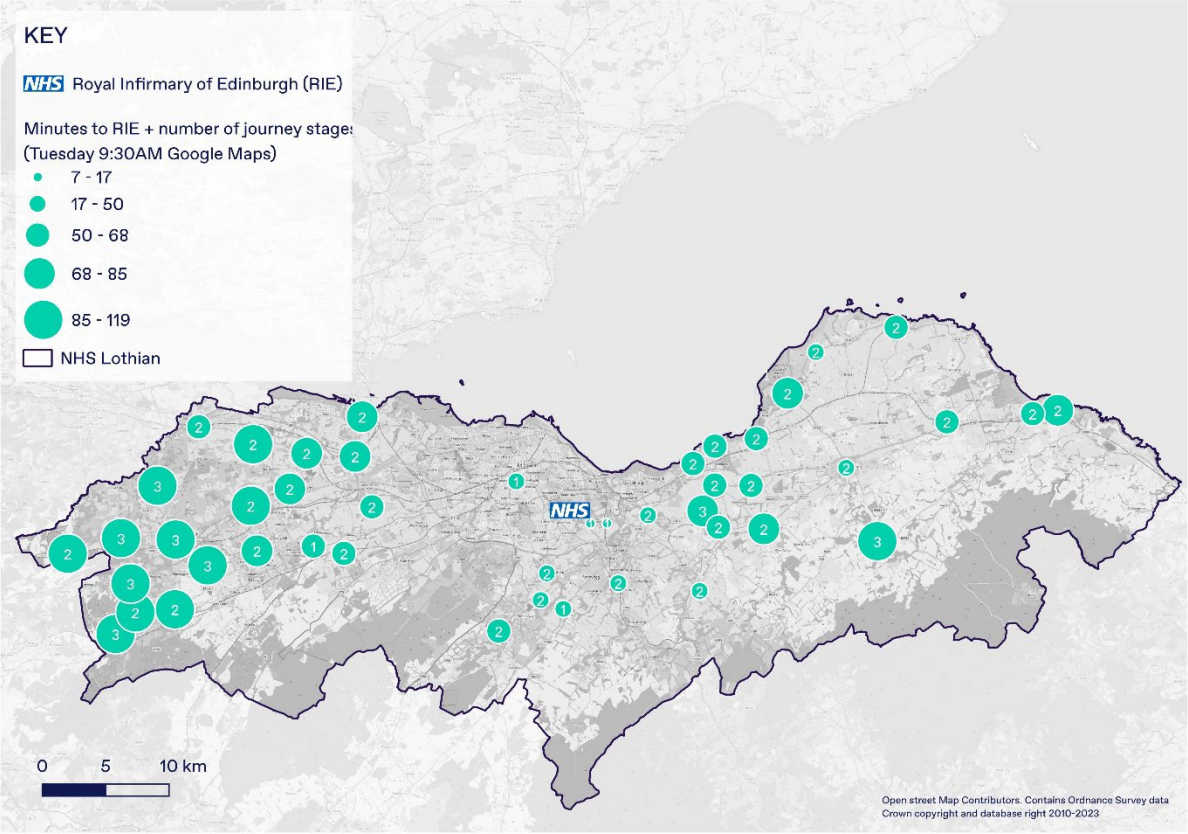


Figure 30: Minutes to RIE and number of journey stages.

Figure 31 shows the proportion of the population which lives in each of the 5 SIMD quintiles. The index of deprivation quintiles represent 5 equal segments of the Scottish population from 1 (most deprived) to 5 (least deprived). All four council areas within the Health Board have a lower than national average proportion of the population in the 20% most deprived areas. The City of Edinburgh has the highest proportion of people in the most deprived quintile, alignining with a lower car ownership rate.

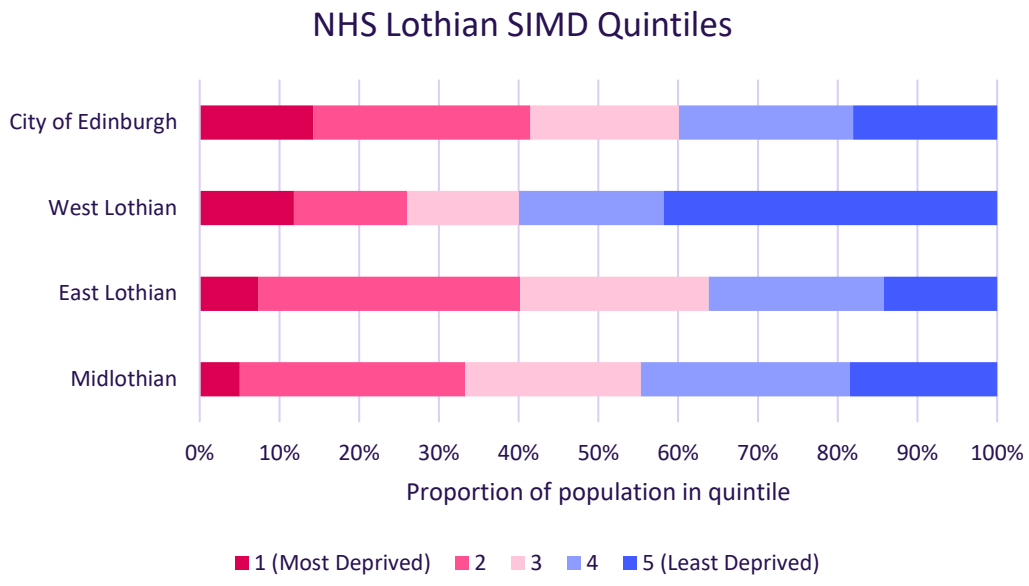


Figure 31: Proportion of NHS Lothian population in each SIMD quintile by local authority

A total of 694 survey respondents live within the NHS Lothian area, providing a strong base of evidence on how residents across Edinburgh, Midlothian, East Lothian and West Lothian currently experience Transport to Health.

Lothian survey respondent characteristics

Survey respondents from NHS Lothian were more likely than the average Lothian resident to have access to a car. When Edinburgh is taken on its own 66% of survey respondents report having access to at least one car, this compares to 62% of Edinburgh's population having access to at least one car via census statistics.

Despite our survey skewing slightly towards car owners, people living in Edinburgh are less likely to have access to a car than SEStran residents overall with 75% of overall respondents reporting access to a car compared to 66% of Edinburgh respondents.

Figure 32 provides a summary of key characteristics of NHS Lothian respondents. Respondents were also much more likely to be women, over 60 years old, providing unpaid care or have a long-term health condition or disability than general population.

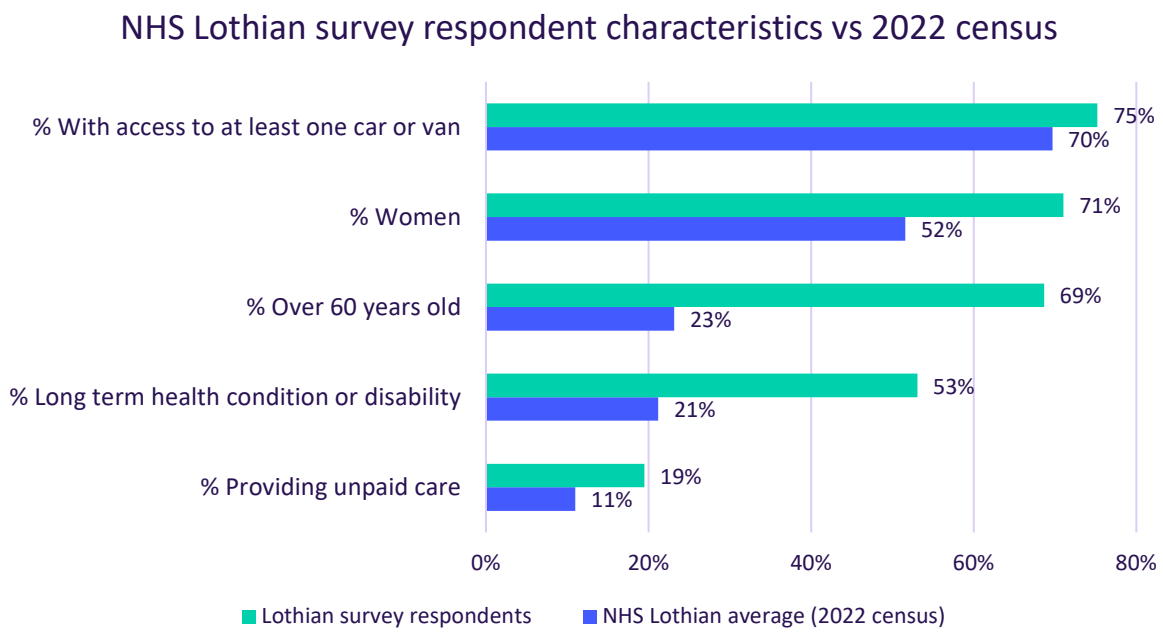


Figure 32: NHS Lothian survey respondents vs Lothian general population (2022 census)

Patterns of healthcare use

Most respondents reported travelling for healthcare infrequently, with the majority of journeys across all appointment types occurring either once a year or less or every few months. GP or local clinic and outpatient appointments were attended more regularly than other services, reflecting their role in ongoing care.

Dental and optician visits were largely infrequent, most commonly reported as once a year or less. Pharmacy visits showed a higher frequency than other services, with a greater proportion of respondents attending every few weeks or monthly. Inpatient travel was least frequent overall and most commonly recorded as not applicable or once a year or less.

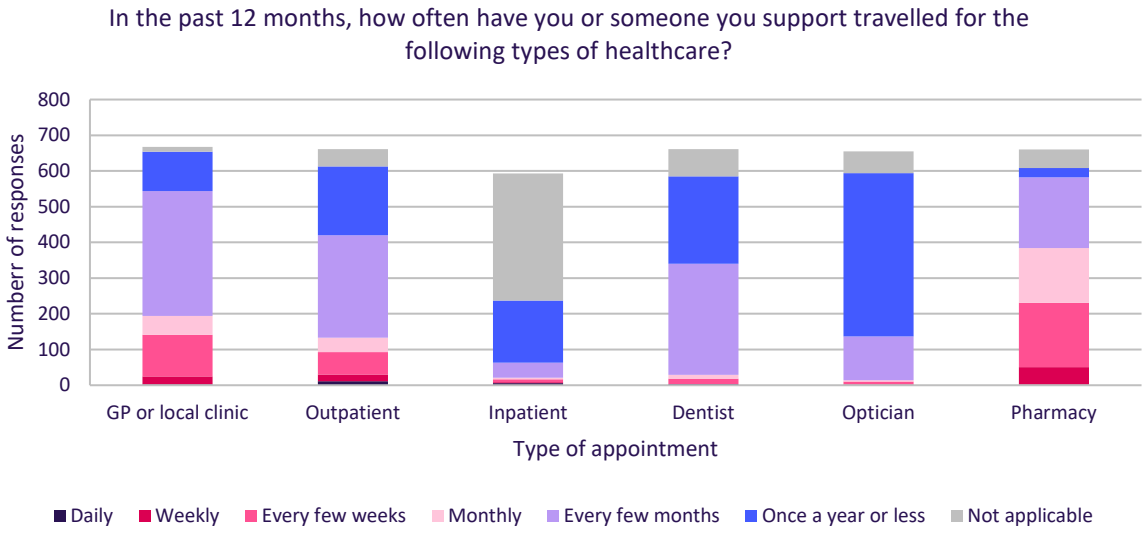


Figure 33: Frequency of visits

The frequency of travel to different healthcare appointment types was consistent between NHS Lothian as a whole and the City of Edinburgh.

How long journeys take

Journey times vary by type of appointment. GP or local clinic and pharmacy appointments were most commonly reached within 15 minutes. Outpatient, dental and optometry trips fall mainly within the 15–30-minute range, while hospital-based or inpatient journeys are more likely to exceed 30 minutes. Inpatient appointments were associated with the longest travel times, with a higher proportion of respondents reporting journeys of over 60 minutes, suggesting greater travel burdens when accessing hospital-based care.

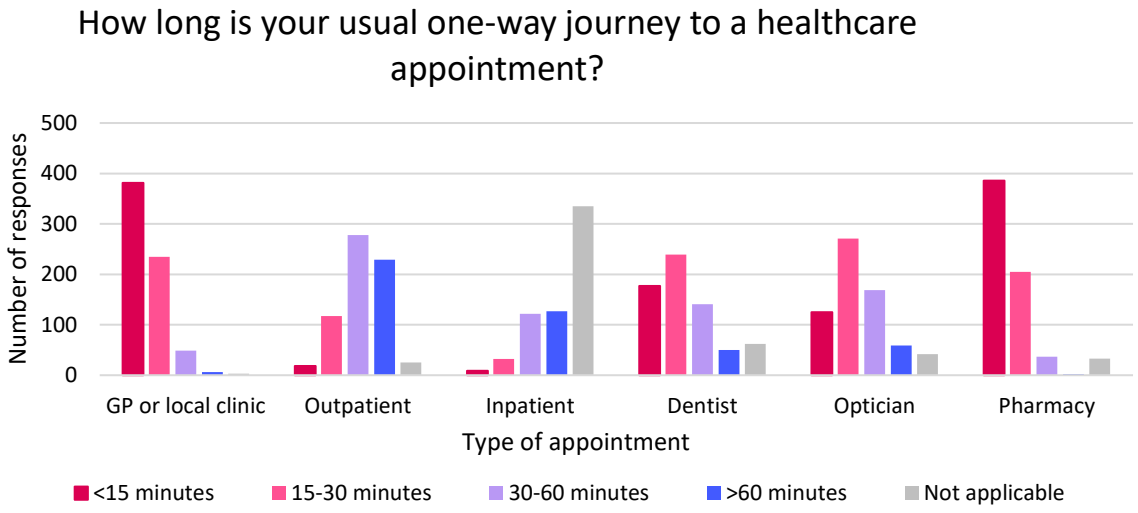


Figure 34: Journey time

The difference in reported journey times between those living in the City of Edinburgh and wider NHS Lothian responses was negligible. A similar pattern of longer journey times for secondary care appointments was evident from respondents in Edinburgh, despite a denser public transport network and closer proximity to large acute hospitals. This may be due to traffic congestion which

affects both car drivers and bus passengers. Some appointments being located at St John's Hospital in Livingston may also contribute to slightly longer journey times.

How people travel to healthcare

Car travel (as a driver or passenger) is the predominant main mode for respondents across the Lothian area. Bus travel represents the most common public transport mode, and is particularly significant in Edinburgh, where respondents report higher levels of bus use. Walking is commonly used for nearby GP or pharmacy appointments.

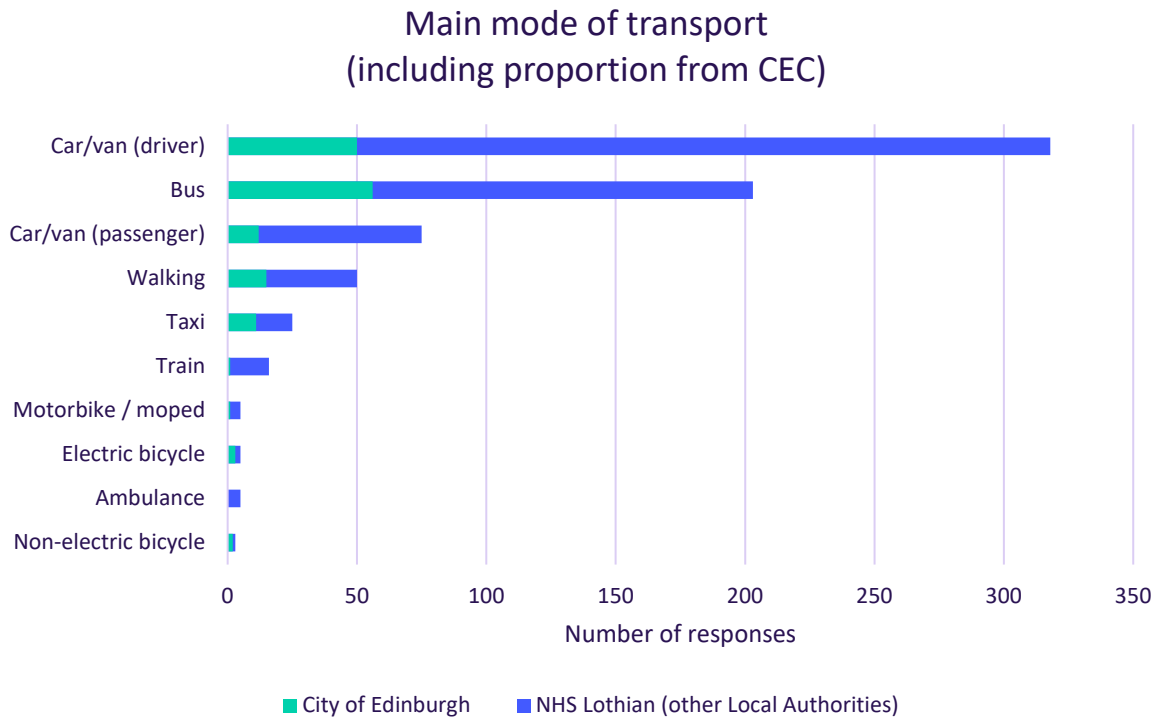


Figure 35: Main mode of transport (including highlight of those from CEC)

In terms of backup options, many respondents indicated that they would switch from their usual mode to public transport or rely on lifts from family or friends if their main option was unavailable. Taxis were also used as a fallback by a smaller proportion of respondents. Many reported having no backup transport mode, highlighting potential vulnerability if their usual travel option is disrupted.

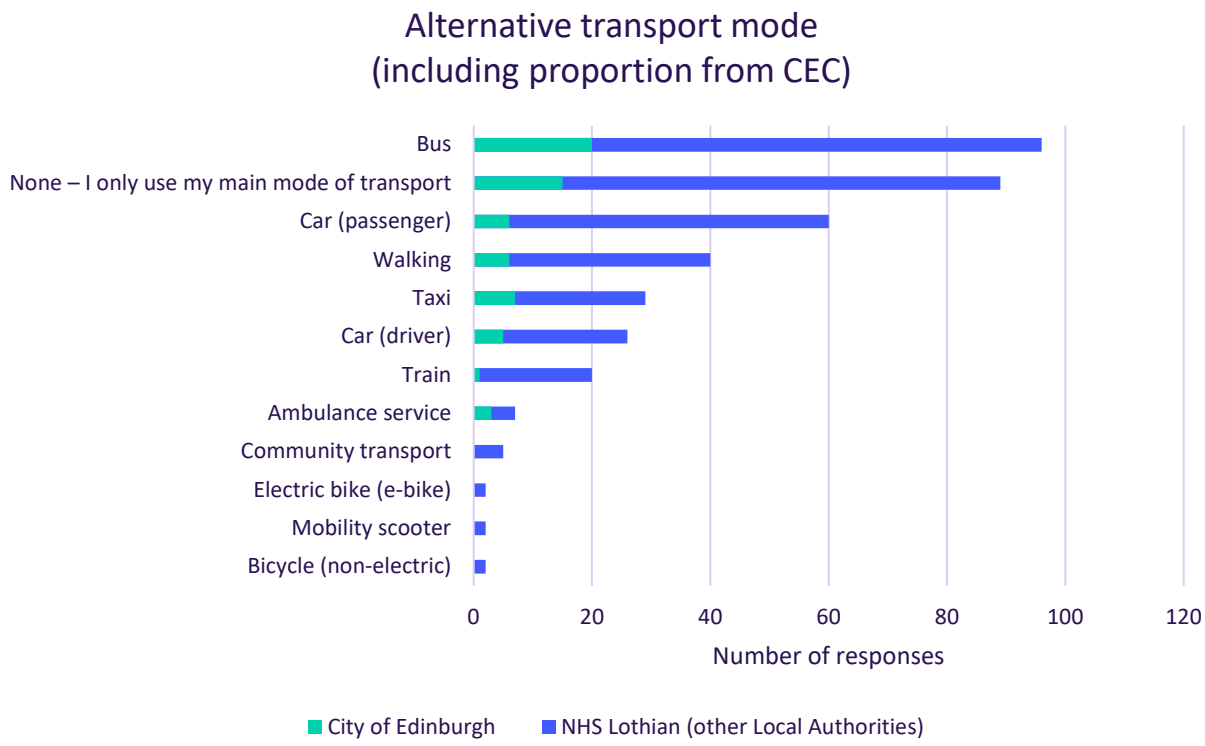


Figure 36: Alternative transport mode (including highlight of those from CEC)

Reliability of available transport

Most respondents reported that their usual transport to healthcare is reliable. Around 44% stated it is usually reliable and a further 30% described it as always reliable. 18% reported that transport is "sometimes unreliable" and 8% "often unreliable", indicating that while overall reliability is generally good, there are pockets of inconsistency that affect a minority of users.

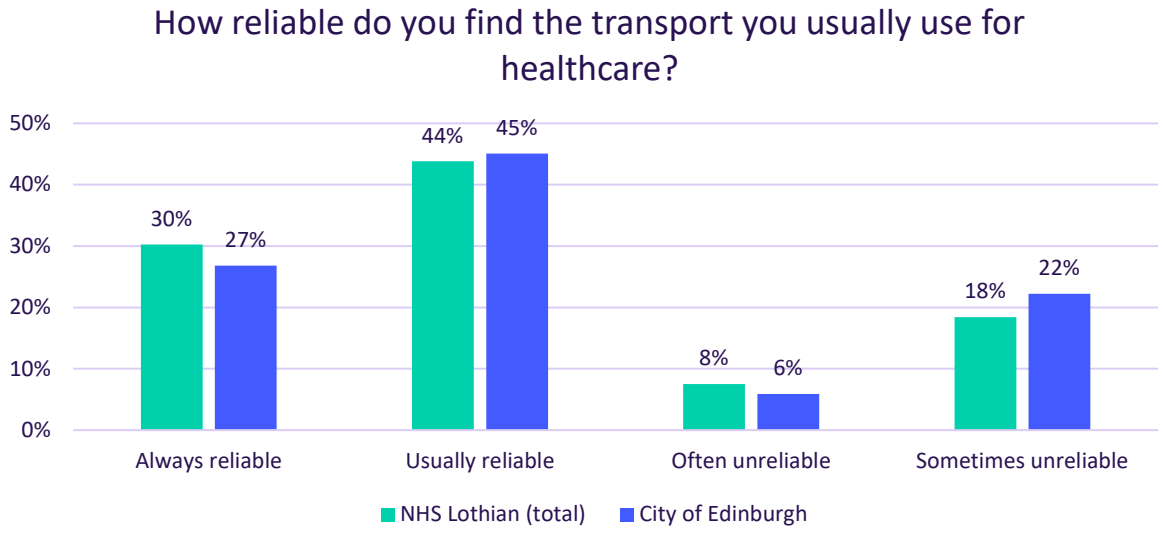


Figure 37: Transport reliability

Missed or delayed healthcare due to transport

Over one third of respondents (36%) reported that they have missed or delayed a healthcare appointment due to transport issues, while 58% said they had not. A small proportion (6%) were unsure. Among those affected, the most common reasons were traffic delays and delayed transport services. Accessibility and mobility issues were also a significant factor. Other contributing reasons included reliance on family for transport and parking difficulties, while costs, poor connections, distance, lack of information and personal car issues were cited less frequently.

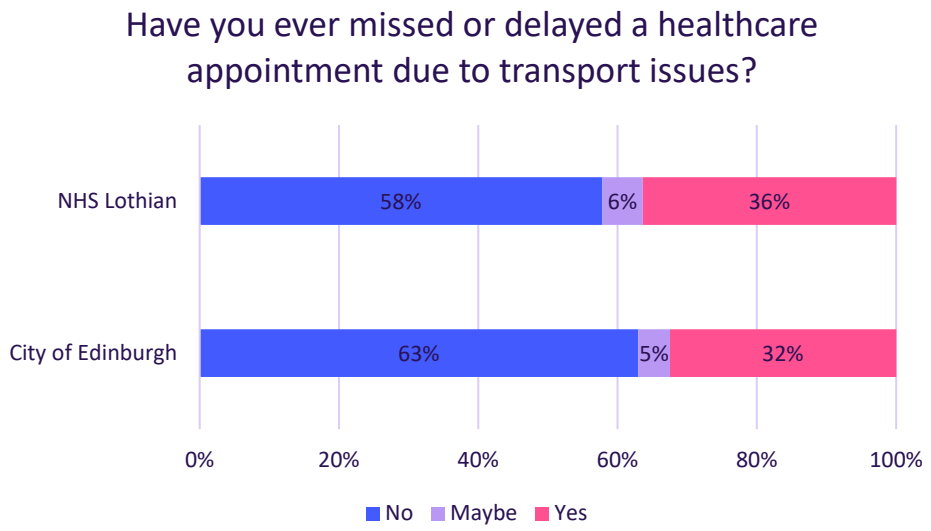


Figure 38: Missed appointments

For those that had missed appointments due to transport issues, the leading reasons were traffic congestion and delayed services. Accessibility and mobility issues were also commonly cited barriers. A smaller number of respondents highlighted over-reliance on family members for lifts and difficulties with parking. Other factors, including poor transport connections, personal care issues, lack of information, cost and distance, were mentioned less frequently.

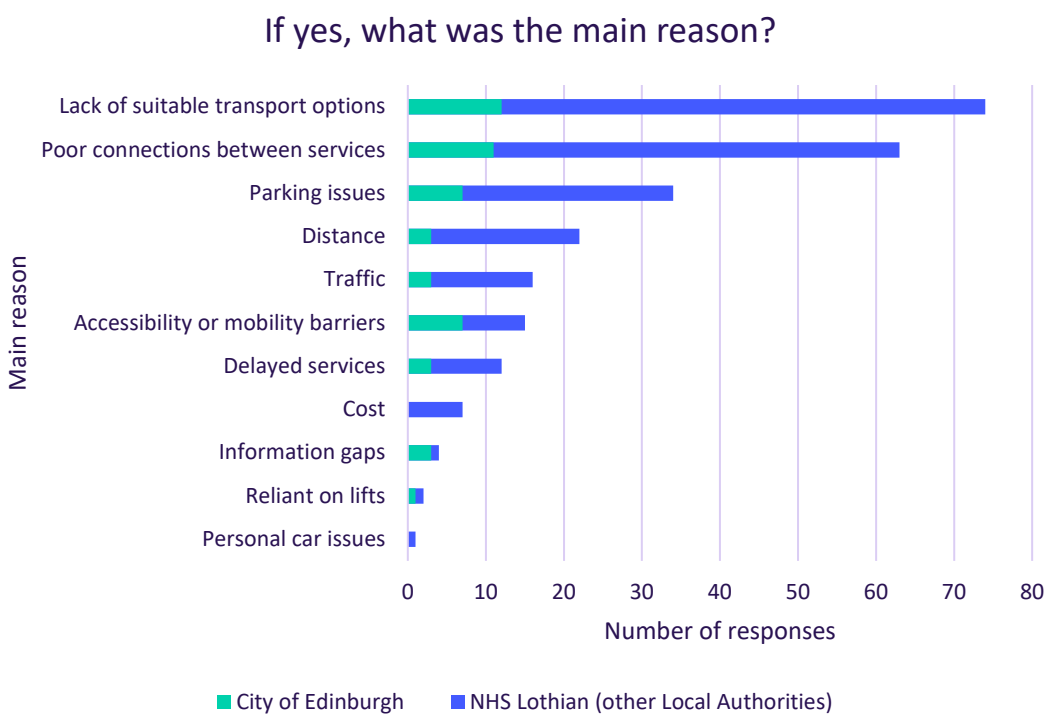


Figure 39: Main reason for missed appointments (including highlight of CEC responses)

Effect of transport costs on attendance

Most respondents (76%) stated that transport costs do not affect their decision or ability to attend healthcare. However, 11% reported that costs do affect their attendance, and a further 13% said that costs sometimes have an impact. This indicates that while cost is not a barrier for most, it remains a significant issue for a minority of patients.

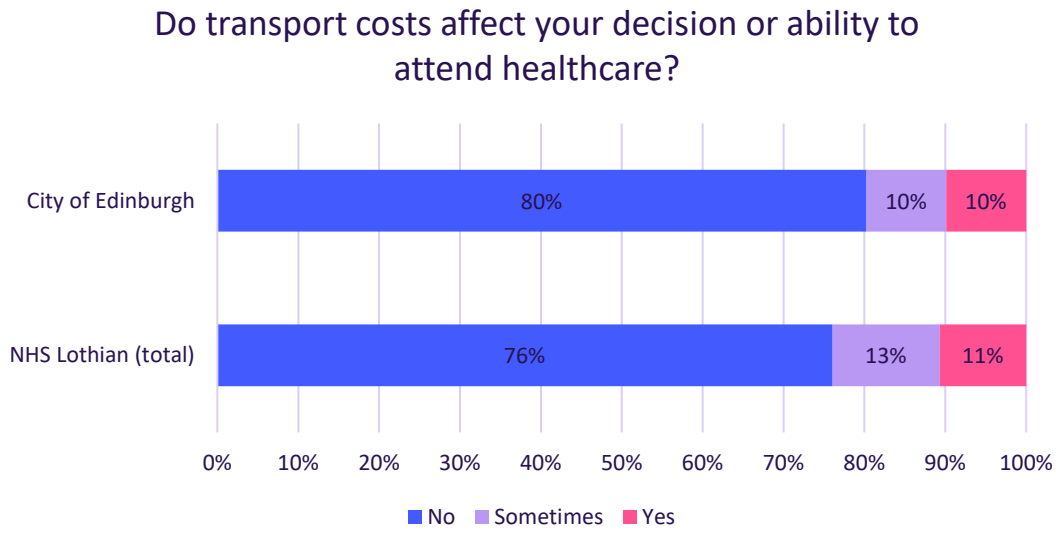


Figure 40: Transport affects healthcare

Cost of the most recent healthcare journey

Most respondents reported that their most recent return journey to a healthcare appointment did not cost anything. Among those who did incur a cost, the majority spent under £10, with the largest proportion paying under £5. Smaller numbers reported spending between £11 and £20, and only a limited number incurred costs above £20.

A small proportion were unsure or unable to remember the cost. Overall, this suggests that while most journeys are low cost or free, a minority of patients face higher travel expenses.

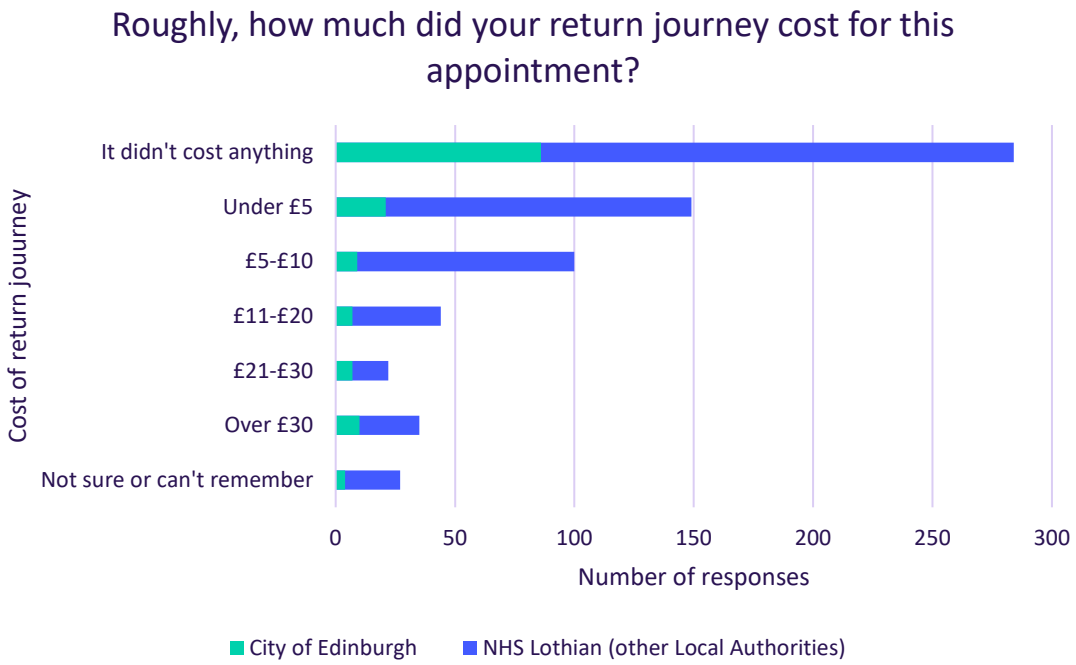


Figure 41: Cost of journey

How people find travel information

Respondents most commonly relied on digital mapping tools such as Google or Bing Maps to find travel information, followed closely by online resources such as Traveline and NHS websites. Information included in patient letters was also an important source. Word of mouth and personal knowledge played a moderate role, while community transport providers, NHS staff advice and local bus apps were used by fewer respondents.

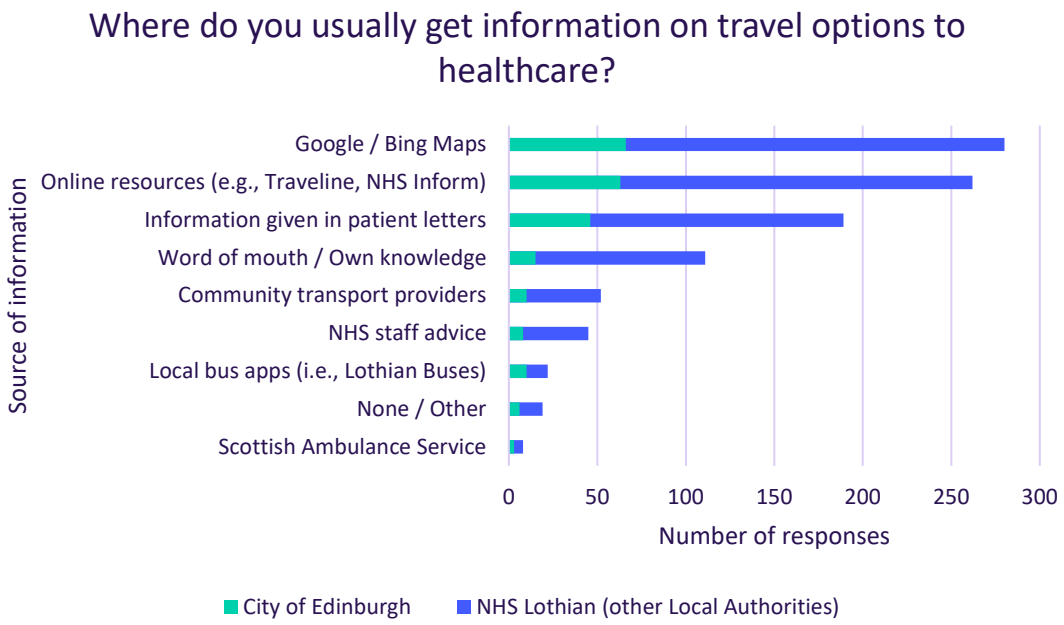


Figure 42: Where do you get your information?

In terms of ease of finding and understanding travel information, most respondents said this is possible "most of the time". A sizeable proportion reported that it is only "sometimes" easy, while fewer stated that it is "always" easy. A notable minority reported that they rarely or never find the information easy to access or understand.

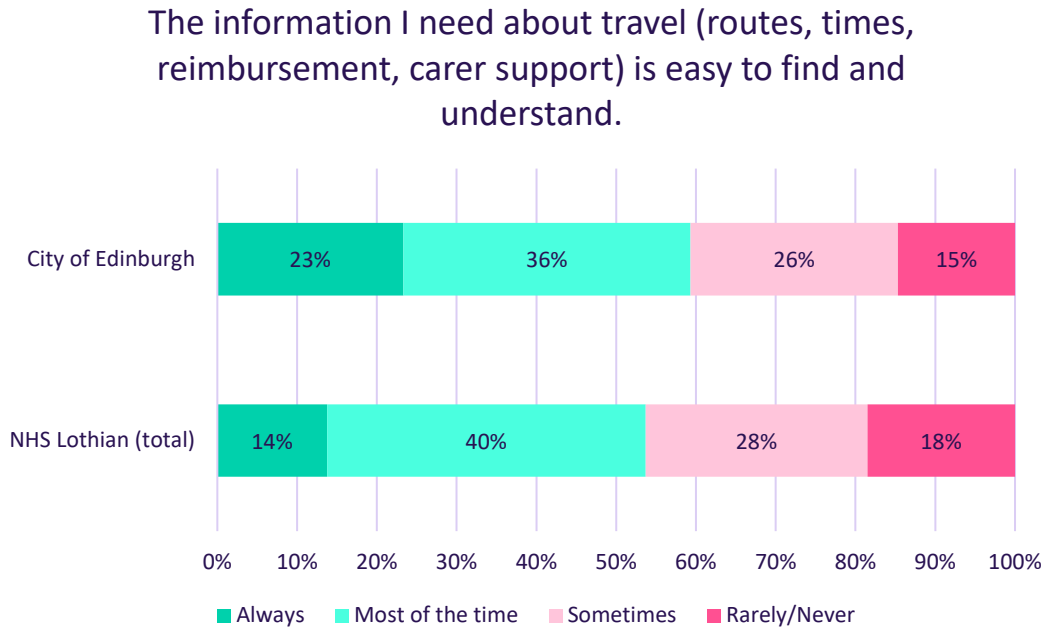


Figure 43: Digestible information

Many respondents reported not needing additional help to find or book transport. However, 'Easier to use digital tools or websites' was the most popular intervention selected. This is followed by paper timetables or leaflets and in-person support. This demonstrates that to improve information about transport options to healthcare appointments a variety of methods need to be employed to reach as

many people as possible.

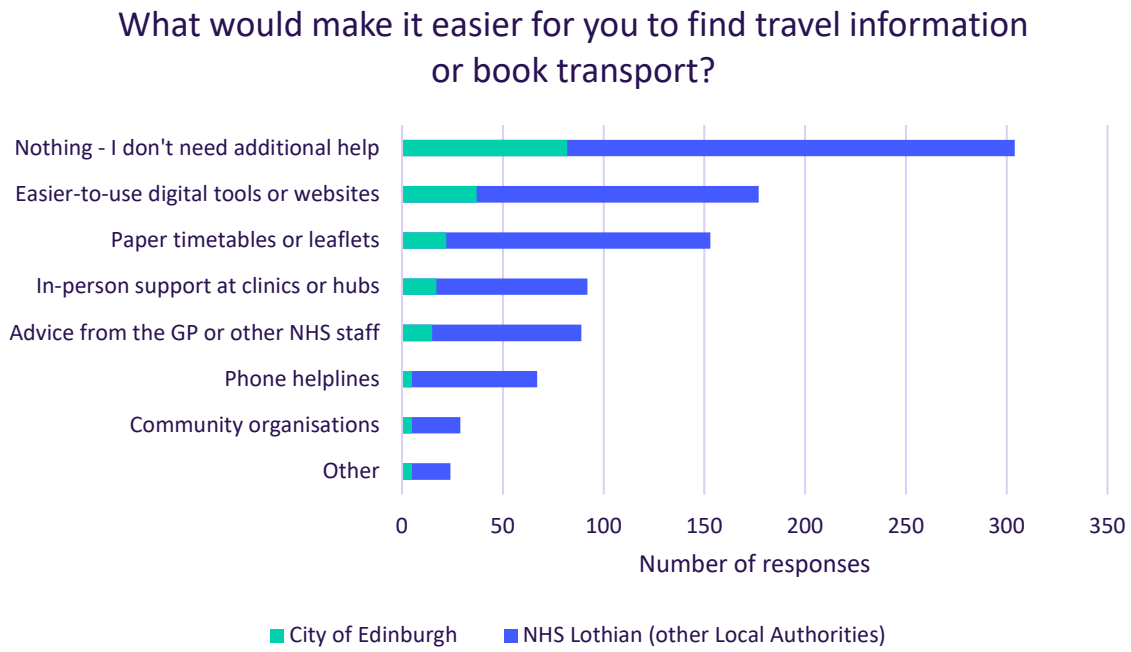


Figure 44: what would make it easier to book?

Digital confidence in planning healthcare travel

Digital confidence is generally high among respondents in NHS Lothian. Most report being “very” or “fairly” confident using online tools for planning or booking transport. A minority indicate limited confidence, highlighting the need for accessible non-digital options.

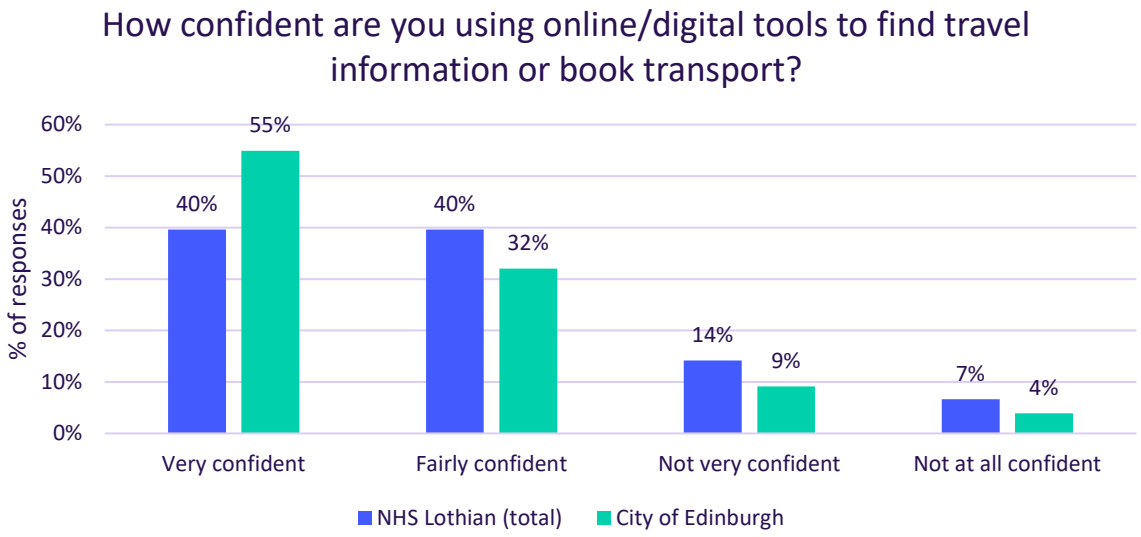


Figure 45: Confidence online

In practice, most respondents usually use digital tools for travel information or booking. A substantial proportion use them sometimes, while fewer reported that they rarely or never use digital tools for

this purpose.

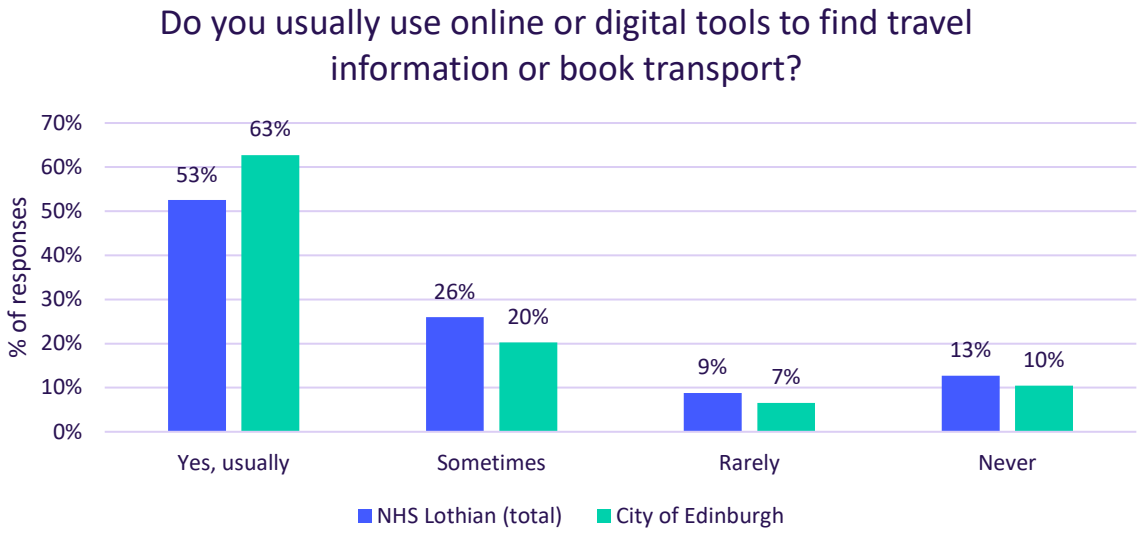


Figure 46: How do you use online tools

Severity of transport barriers

Respondents identified several significant transport barriers affecting access to healthcare. The most severe and commonly reported issue was the lack of direct public transport routes to healthcare facilities. Parking difficulties were also a major concern, particularly for hospital-based appointments. Poor connections between different transport services, such as bus, rail, taxi and community transport, were highlighted as a further barrier. A moderate number of respondents also reported challenges linked to limited service availability and difficulties with coordination and information across agencies. Cost and access to appropriate support for disabled people and carers were identified as additional, though less widely reported, barriers.

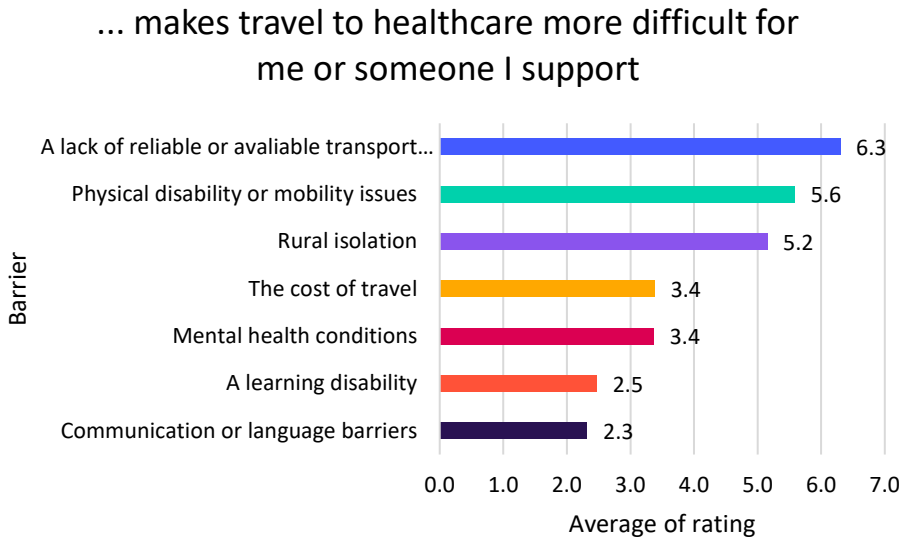


Figure 47: Difficulties with travel

Responses from the City of Edinburgh followed a similar pattern to those of NHS Lothian overall. However, the salience of 'Rural isolation' as a barrier to healthcare travel was much reduced for Edinburgh residents.

Which groups experience the greatest barriers

People with disabilities and long-term health conditions were more likely to experience accessibility and mobility-related barriers, including difficulties using public transport and reliance on others for lifts. Older people were more affected by digital barriers, limited service availability and reduced confidence in using online tools.

Carers frequently reported time pressures, reliance on others, and the complexity of coordinating transport around caring responsibilities.

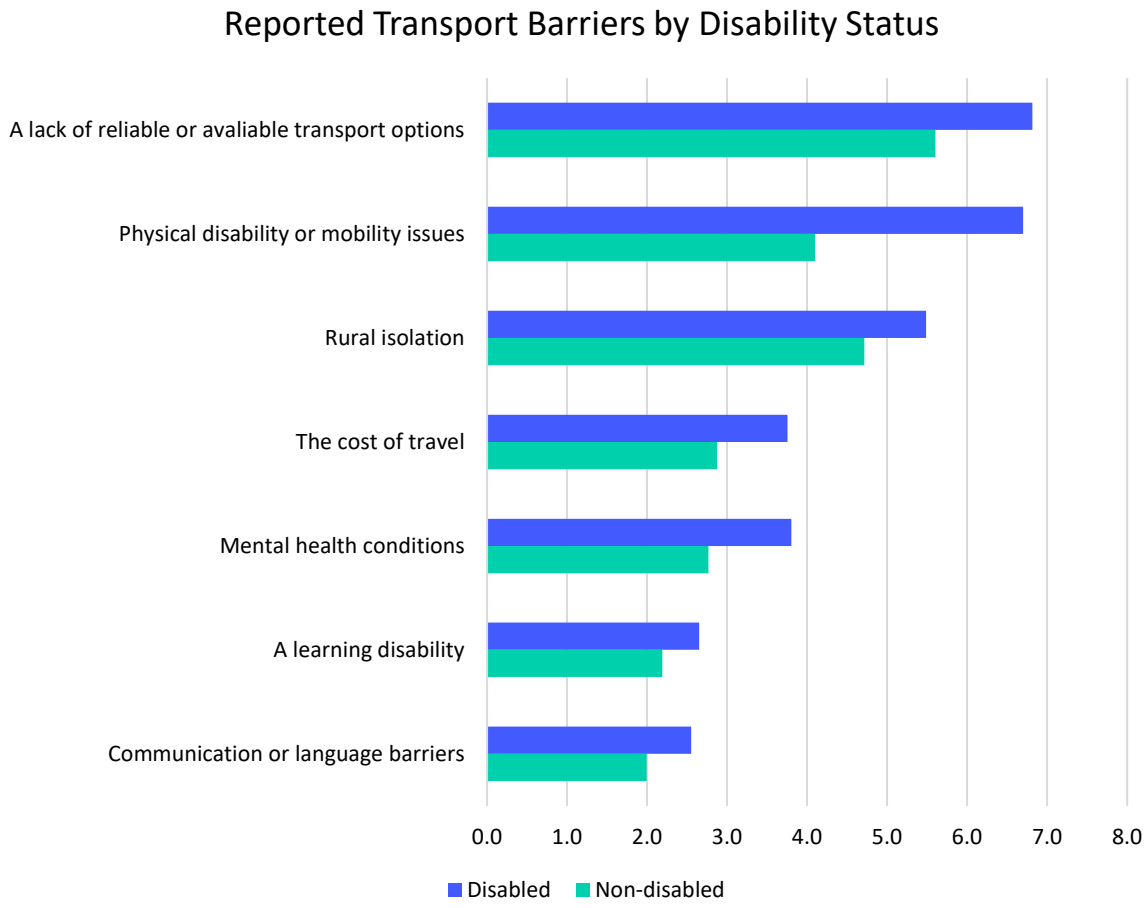


Figure 48: Transport barriers

What solutions people will consider

The most likely solution respondents were to consider to help access healthcare was remote consultations. This shows there is a willingness among patients to receive more care without travelling to appointments in person, this could help reduce journeys to healthcare for some suitable use cases. Hospital or clinic transport was the second most popular option, demonstrating a strong demand for purpose use transport especially for healthcare. The third most popular option and the most popular option for Edinburgh residents was 'I would not consider using any of these'. This demonstrates that a large proportion of people are looking for alternatives solutions to improve

transport to health such as more direct, frequent transport to healthcare sites and better availability of parking at hospitals.

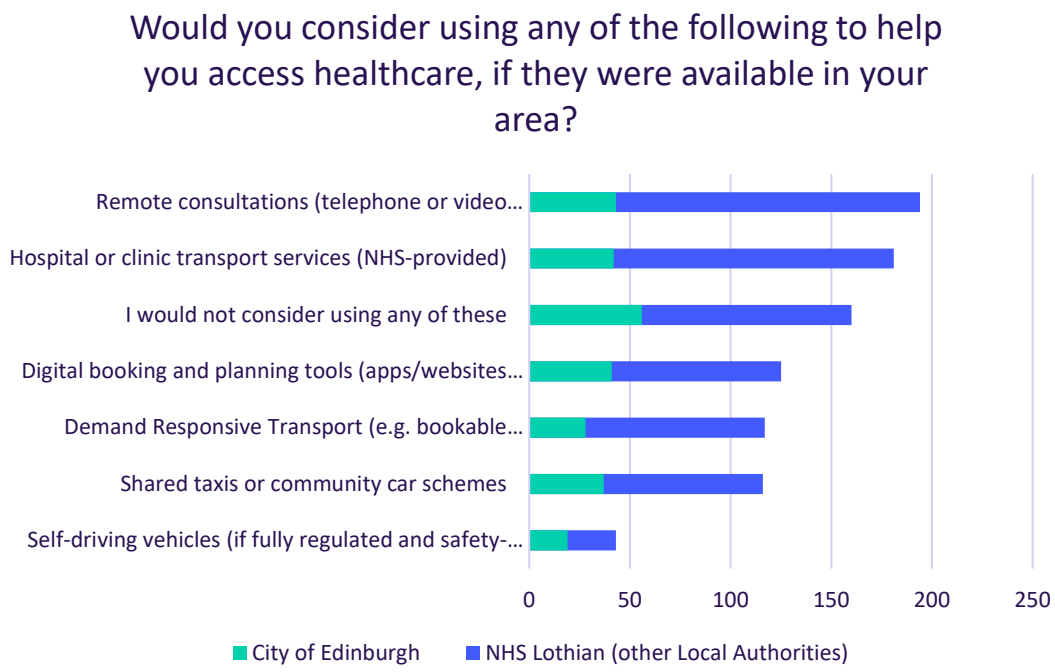


Figure 49: What would help access healthcare

Qualitative insights: Lived experience of travelling to healthcare

Open-text responses from NHS Lothian residents provide important context to the survey findings. Several consistent themes emerged across Edinburgh, East Lothian, Midlothian and West Lothian, reflecting a combination of long journeys, indirect routes, accessibility issues and reliance on private or informal transport.

Indirect, lengthy or multi-stage public transport journeys

Across NHS Lothian, respondents consistently described significant challenges related to the availability of accessible transport, long journey times and the distance to healthcare services. For many, accessing hospital care requires multiple bus journeys, long travel times and complex planning, particularly where there is no direct bus route to major hospital sites.

Several respondents reported that travelling to hospitals such as the Royal Infirmary of Edinburgh, Western General and St John's Hospital often requires two buses or a combination of bus, train and taxi, with journeys taking up to 90 minutes each way or longer. One participant explained:

> "If my husband is not available to drive us it's two buses to get to RIE... which can take anything from 35 minutes to 1 hour 15 minutes each way."

Long journeys were particularly difficult for those who do not drive:

"I don't drive so rely on public transport and living at the opposite side of the city to the hospital takes almost 1.5 hours each way."

Distance to services was also linked to the centralisation of care, with people frequently being referred outwith their local area for treatment. This resulted in journeys that were described as time-consuming, stressful and costly, especially for older people:

"We are elderly… we need to drive to the railway station, catch the train and take a taxi. This can be expensive and takes up a lot of time."

In some cases, people were required to travel over 28 miles for day surgery, which was viewed as unreasonable and avoidable where local facilities exist:

"Don't send people 28 miles away for day surgery."

Lack of direct routes and reduced bus frequencies

A recurring theme was the lack of direct public transport routes to NHS facilities, even from densely populated areas. Respondents described routes being indirect, poorly connected or having reduced frequency over time.

One respondent from Leith highlighted the impact of this on someone with limited mobility:

"There is no direct bus from Leith to the Western General… my partner is not up to walking between bus stops or sitting waiting for the connecting bus."

The absence of direct services was particularly problematic for regular outpatient and secondary care appointments:

"The difficulty for me is there is no direct bus to ERI which I have to attend every 6 months."

Indirect routes often added significant additional travel time and resulted in time off work:

"Indirect bus services approx. 2 hours one way (time off if workday)."

Parking pressures and continued reliance on the car

Parking availability at hospitals was another commonly reported barrier. Even where respondents had access to a car and a Blue Badge, parking close to hospital entrances was not guaranteed:

"My husband has a blue badge, but you can't guarantee a parking place that is close enough to hospital."

As a result, some respondents felt forced to use cars despite preferring public transport, particularly when connecting bus services were unreliable or physically demanding. Park and Ride was used as a compromise by some, although this still increased journey length:

> "I am more likely to drive to the Park & Ride and then get a bus… which makes it a much longer journey."

Accessibility barriers for disabled people and those with long-term conditions

For people with limited mobility, transport challenges were compounded by limited accessible options. Respondents highlighted a shortage of wheelchair-accessible taxis, with many tied into school transport contracts:

> "Only a few taxis in our area take wheelchairs and a lot of these are tied into school contracts."

> "My partner can't manage the walk between connecting buses."

Health conditions also influence travel planning:

> "We have to consider times if she needs to access toilets which could mean getting off a bus to find a toilet."

These factors made public transport unpredictable, physically demanding and unsuitable for some patients.

Cost, stress and reliance on informal support

For those without access to a car, arranging transport often depended on family, friends or lifts, creating stress and uncertainty, especially following procedures:

> "If we can't get a lift, I don't know what we'll do as we can't afford a taxi, and he can't get a bus when he's had a painful surgical procedure."

Transport costs were also a concern for longer journeys involving trains and taxis. This created an additional burden for older people and those on fixed incomes:

> "We are elderly… train plus taxi is expensive and takes a lot of time."

Summary of insights for NHS Lothian

Evidence for NHS Lothian highlights a series of transport pressures shaped by the centralisation of acute care in Edinburgh and the diverse settlement patterns across the Health Board.

Key themes emerging from the data and lived experience

↘ Hospital journeys are significantly longer and more complex than primary care travel

Many residents across East Lothian, Midlothian and West Lothian report hospital journeys of 60–90 minutes involving two buses or multimodal trips, reflecting indirect connections to major sites such as RIE, WGH and St John's.

↘ Lack of direct public transport routes is the most consistently reported barrier

Indirect services, limited frequency and poorly aligned timetables particularly affect regular outpatient users and those travelling for specialist care.

↘ Continued dependence on private cars despite parking pressures

Although Edinburgh has good public transport coverage, many respondents rely on driving due to journey complexity and accessibility issues.

↘ Disabled people and those with long-term conditions face disproportionate barriers

Limited availability of accessible taxis, long walking distances between interchanges and the physical demands of multi-stage travel make public transport unsuitable for many.

↘ Cost is not a universal barrier but can be significant for those without car access

Rail–taxi combinations and long bus trips impose financial strain, especially on older and low-income residents.

↘ Spatial disparities are clear across the Board area.

Edinburgh respondents experience shorter, more reliable journeys, whereas outer authorities report the longest travel times, higher reliance on informal support and the fewest direct hospital connections.

Overall NHS Lothian performs relatively well for primary care access but less effectively for hospital and specialist appointments, creating a pattern of disadvantage for disabled people, older adults and residents living further from Edinburgh's main hospital sites.

NHS Fife – evidence summary

Area overview

NHS Fife covers a geographically diverse area that includes coastal towns, mid-sized urban centres and extensive rural communities. Settlement patterns are shaped by the Firth of Forth coastline, former mining towns across central Fife, and rural hinterlands in the north and east of the region. Major towns include Dunfermline, Kirkcaldy, Glenrothes and St Andrews, alongside smaller communities such as Cupar, Leven, Anstruther and Cowdenbeath.

Two acute hospitals serve the area:

- Victoria Hospital, Kirkcaldy (VHK) – the main district general hospital providing most acute and specialist services
- Queen Margaret Hospital, Dunfermline (QMH) – providing a range of outpatient and elective services

These hospitals sit within dense or semi-urban areas in central and west Fife, meaning that residents in rural northern and eastern parts of the region often face longer and more complex journeys to reach secondary care. Several community hospitals and primary care centres supplement this network, but many specialised services require travel to VHK or to hospitals in neighbouring NHS Lothian.

Fife's transport network is shaped by major road corridors including the A92, A915 and A985, and a rail network serving the Fife Circle, Edinburgh, Dundee and Aberdeen routes. However, rail coverage is uneven, with large parts of East Neuk, North Fife and rural inland areas located far from train services. Bus provision is dense in larger towns yet significantly thinner in rural areas, contributing to pronounced differences in healthcare accessibility.

These structural patterns are illustrated in the following GIS maps:

Figure 50 shows distribution of major settlements, road connectivity and rail availability.

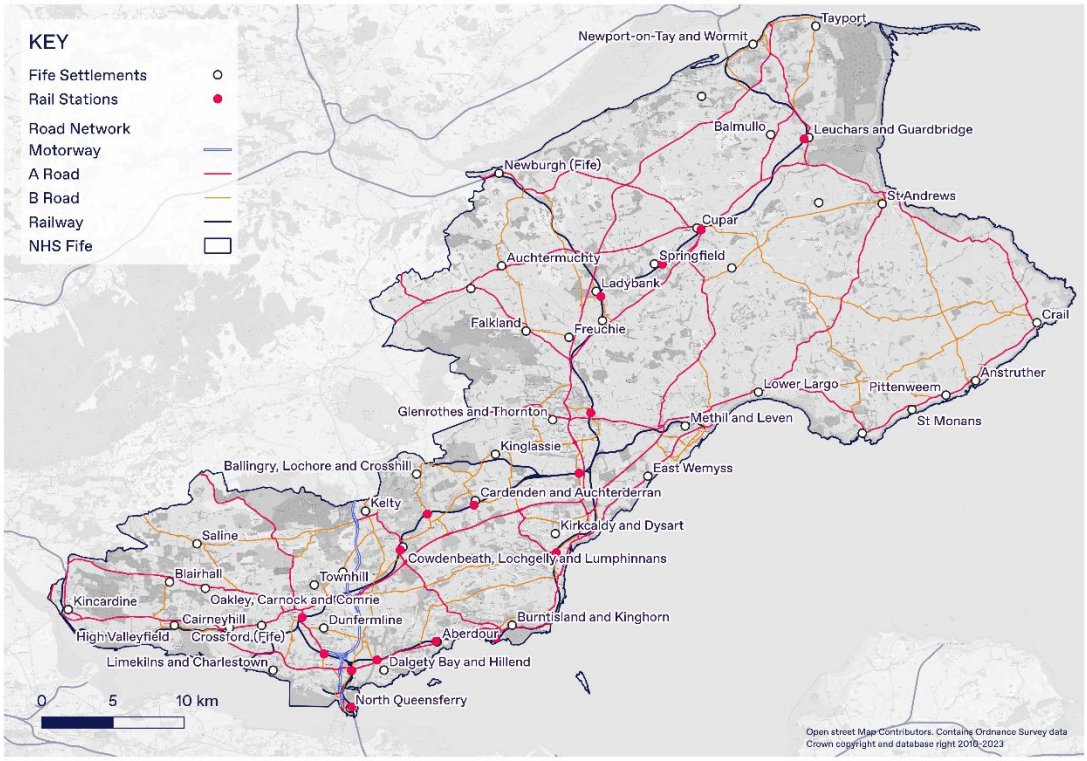


Figure 50: Distribution of major settlements, road connectivity and rail availability

Figure 51 shows GP surgeries, community hospitals and the two acute hospitals, highlighting rural areas with greater travel distances.

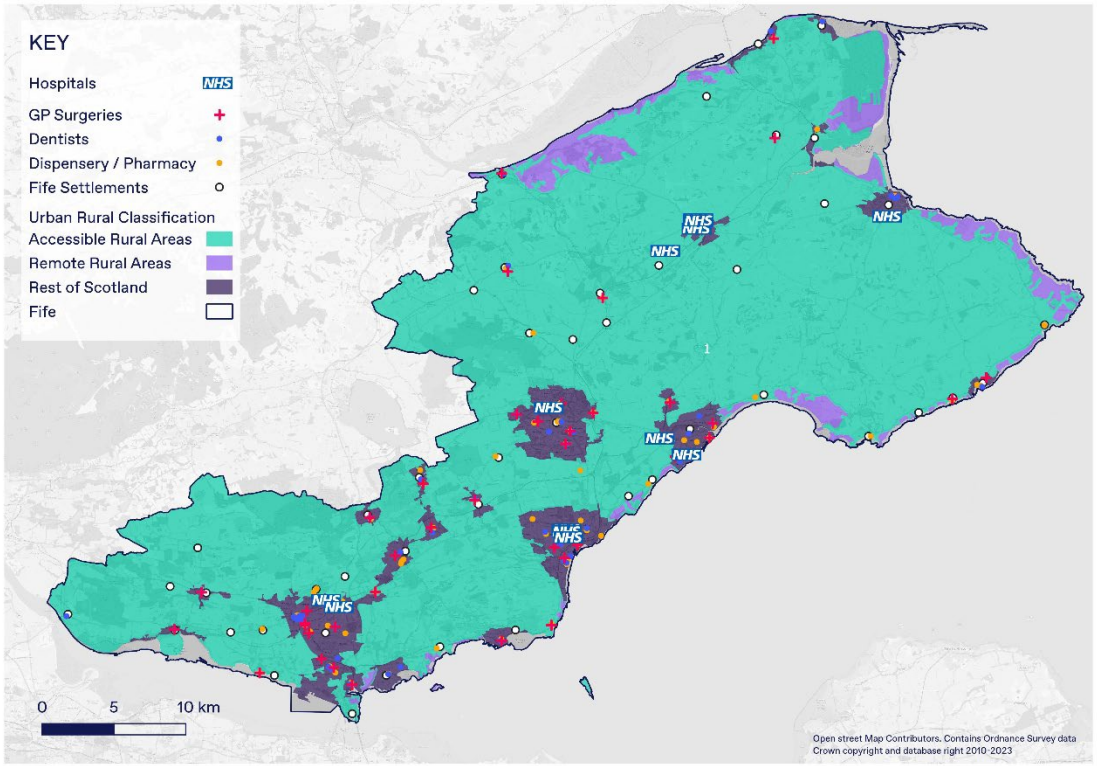


Figure 51: Distribution of services

Figure 52 illustrates variation in journey time and public transport complexity across central, western, northern and eastern Fife.

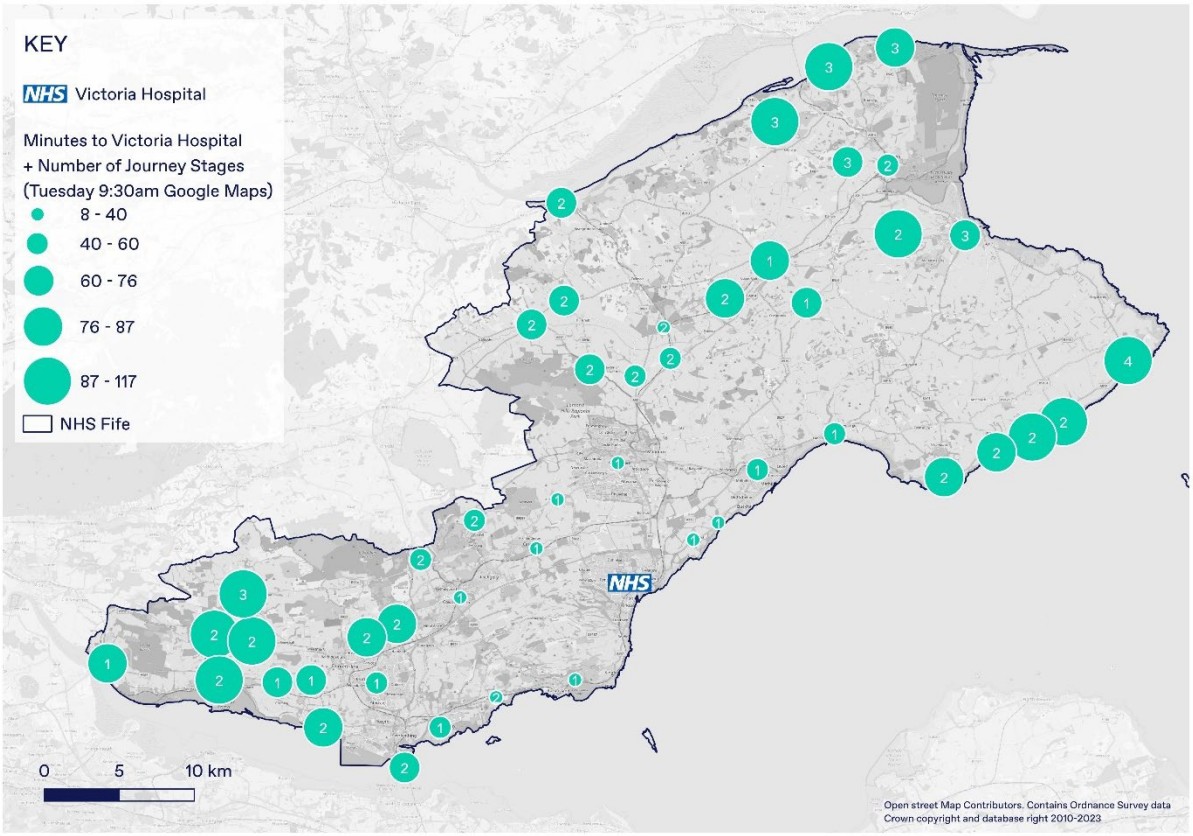


Figure 52: Journey time variation

Figure 53 shows the proportion of the population which lives in each of the 5 SIMD quintiles. The index of deprivation quintiles represent 5 equal segments of the Scottish population from 1 (most deprived) to 5 (least deprived). NHS Fife aligns with the Scottish average with each quintile containing roughly 20% of the population, meaning that there is a an equal distribution of deprived and less deprived areas.

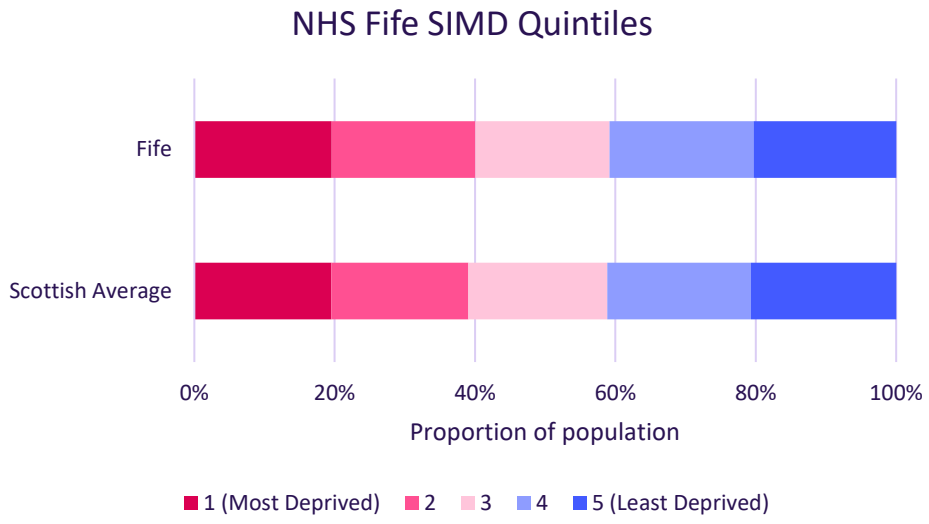


Figure 53: NHS Fife proportion of the population in each quintile

A total of 225 survey respondents live within the NHS Fife area, providing insight into how residents across urban, semi-urban and rural communities currently experience travel to healthcare.

NHS Fife Survey respondent characteristics

Survey respondents from Fife were more likely to have access to a car than survey respondents overall by a margin of +5%. This reflects the more mixed rural and semi-urban setting of much of the authority area.

Survey responses from Fife are consistent with overall survey characteristics, with a greater proportion of older people and women responding to the survey than the general population.

Fife is notable for having a much greater proportion of people living with long term health conditions or disabilities both in terms of the general population and respondents to this survey. The 2022 census reveals that Fife has +4% more people than the SEStran living with a long-term health condition/disability, while our survey has an increase of +6% compared to overall survey results.

Fife also has a greater proportion of people providing unpaid care. The 2022 census shows 13.9% of Fife residents provide unpaid care compared to 11.5% in SEStran overall. This is reflected in our survey where 26% of respondents provide unpaid care compared to 21% in overall survey results.

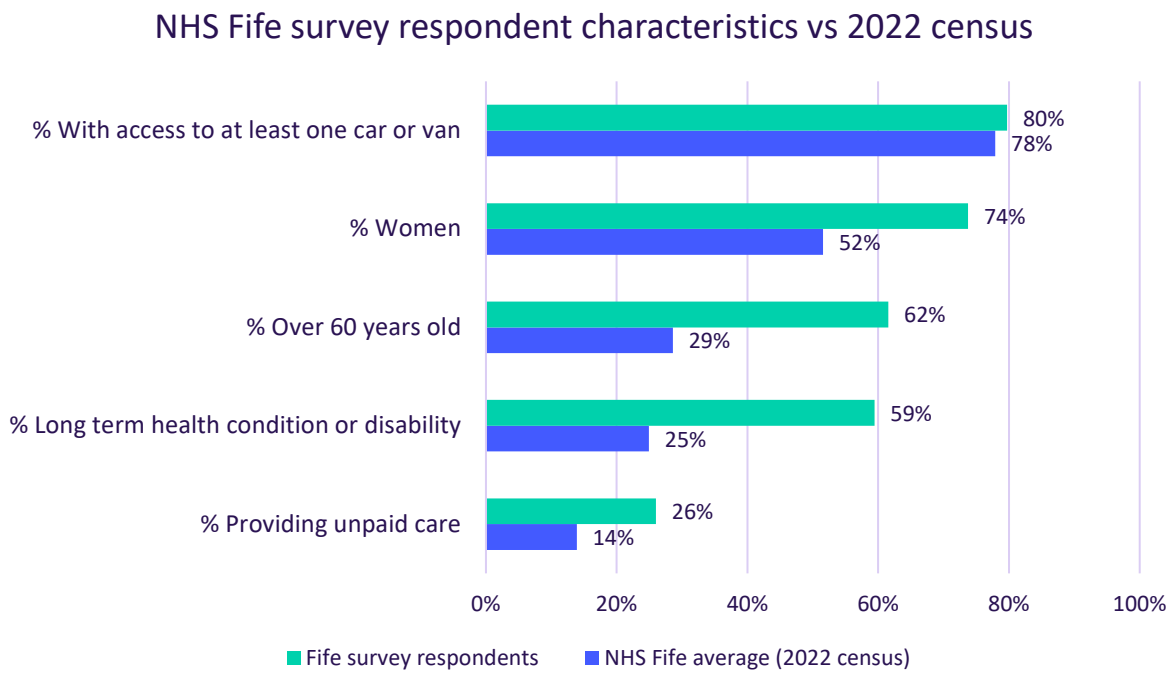


Figure 54: NHS Fife Characteristics – respondents vs census

Patterns of healthcare use

Within NHS Fife, most respondents reported travelling for healthcare infrequently, with the majority of journeys across all appointment types occurring either once a year or less or every few months. GP or local clinic and outpatient appointments were attended more regularly than other services, reflecting their role in ongoing care.

Dental and optician visits were largely infrequent, most commonly reported as once a year or less. Pharmacy visits showed a higher frequency than other services, with a greater proportion of

respondents attending every few weeks or monthly. Inpatient travel was least frequent overall and most commonly recorded as not applicable or once a year or less.

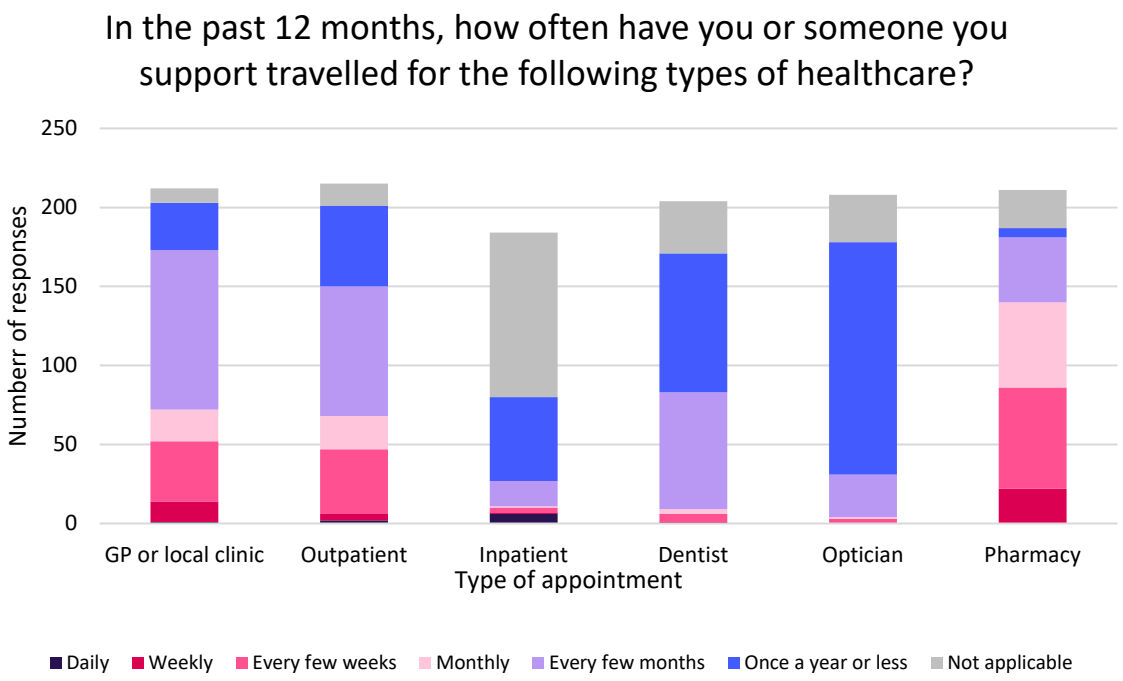


Figure 55: Frequency of visits

How long journeys take

Across NHS Fife, most journeys to healthcare appointments were relatively short. GP or local clinic and pharmacy appointments were most commonly reached within 15 minutes, indicating generally good local access to community-based services. Journeys to outpatient, dentist and optician appointments were more mixed, with many respondents reporting travel times of 15–30 minutes and 30–60 minutes. Inpatient appointments were associated with the longest journeys, with a higher proportion of respondents travelling over 60 minutes, reflecting the more centralised nature of hospital services within Fife.

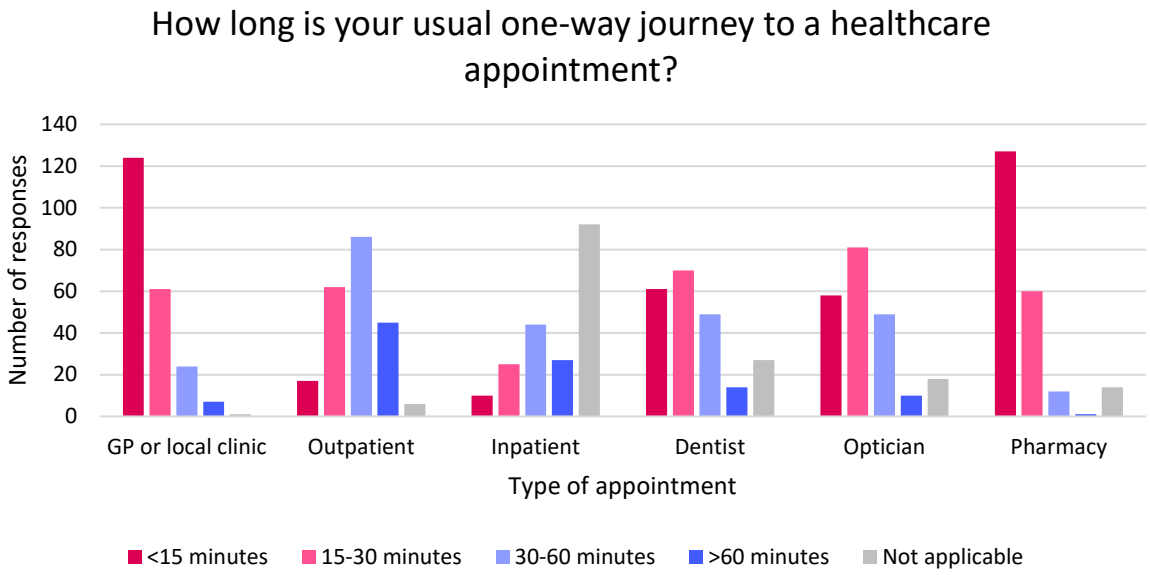


Figure 56: Journey time

How people travel to healthcare

Respondents in NHS Fife reported using a mix of transport modes to access healthcare, with the private car being the most common main mode of travel, either as a driver or passenger. Bus services were the next most frequently used option, particularly for those without access to a car. Use of taxis and walking was less common.

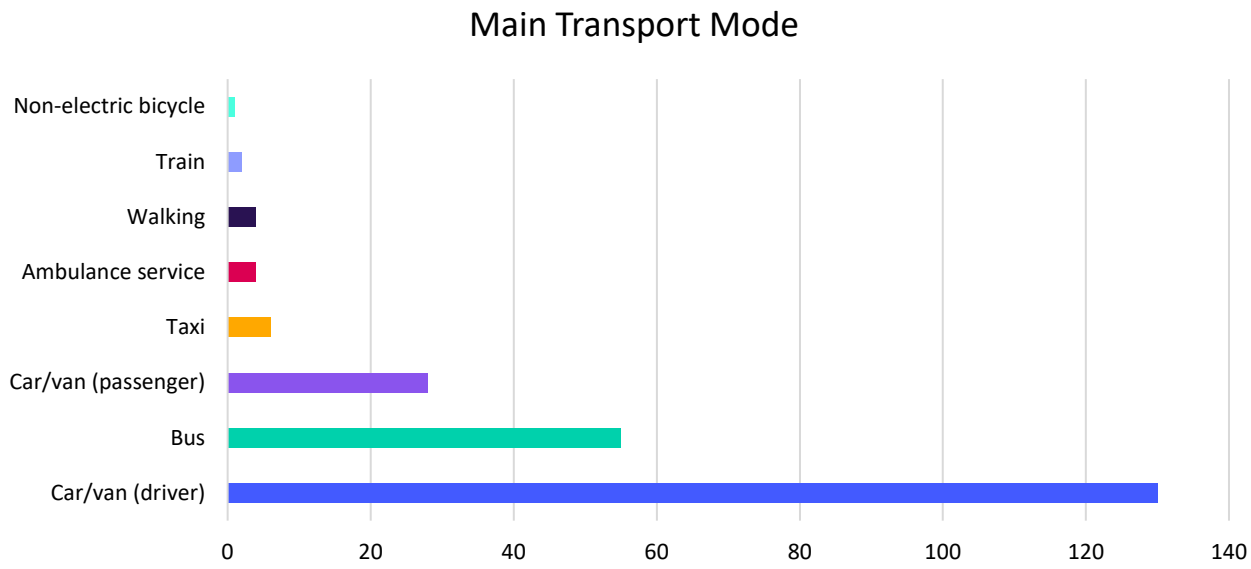


Figure 57: Main mode of transport

The most popular option for respondents was that they didn't have a backup option to their main mode of transport. Among those who reported having an alternative transport option, many respondents indicated that they would rely on family or friends for lifts if their usual mode was unavailable. Public transport, particularly buses, was also commonly used as a secondary option. A smaller number identified taxis as their main alternative.

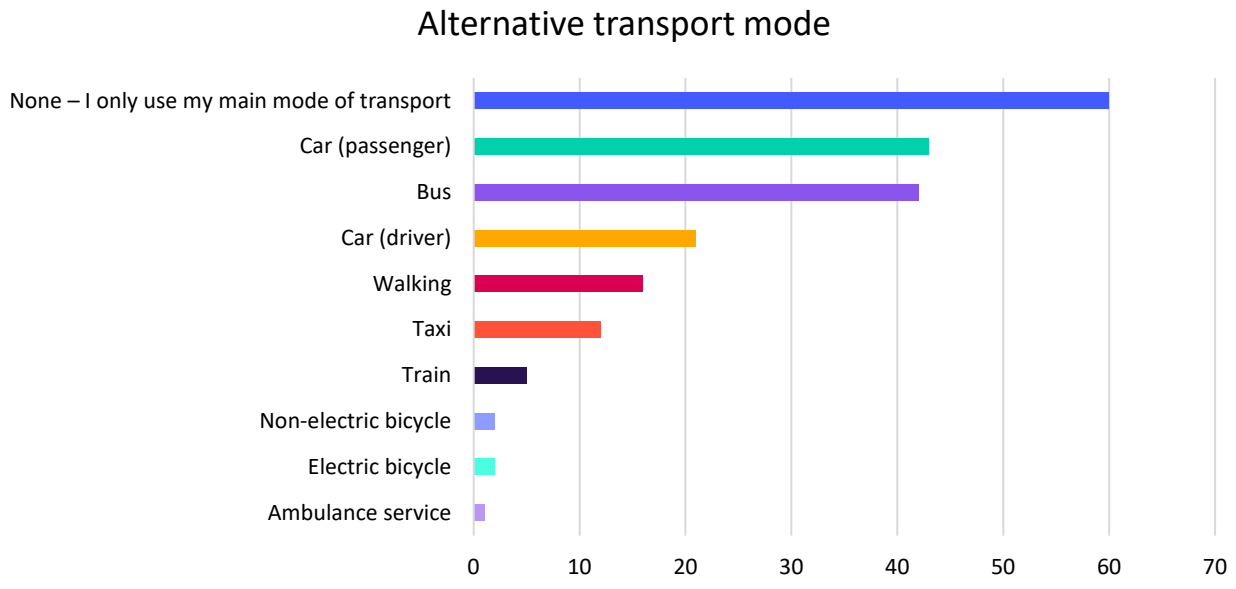


Figure 58: Alternative transport mode

Reliability of available transport

Most NHS Fife respondents reported that their usual transport to healthcare is reliable. The largest group described their transport as “usually reliable”, followed by those who said it is “always reliable”. A smaller proportion experienced some issues, reporting that their transport is “sometimes unreliable”. Only a small minority stated that it is “often unreliable”, indicating that overall reliability across Fife is generally good, but not consistent for all users.

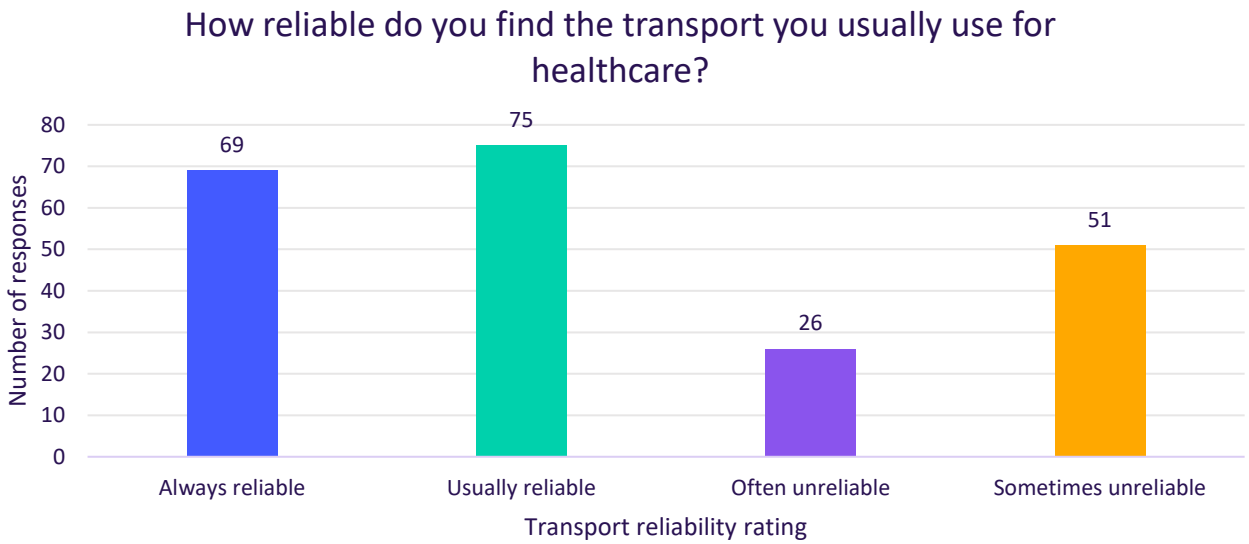


Figure 59: Transport reliability

Missed or delayed appointments due to transport

44% of NHS Fife respondents reported that they have missed or delayed a healthcare appointment due to transport issues, the highest proportion of any Health Board in the region.

For those affected, the leading reasons were traffic congestion and delayed services. Accessibility and mobility issues were also commonly cited. A smaller number of respondents highlighted reliance on family for transport and difficulties with parking. Other factors, including poor transport connections, personal car issues, lack of information, cost and distance, were mentioned less frequently.

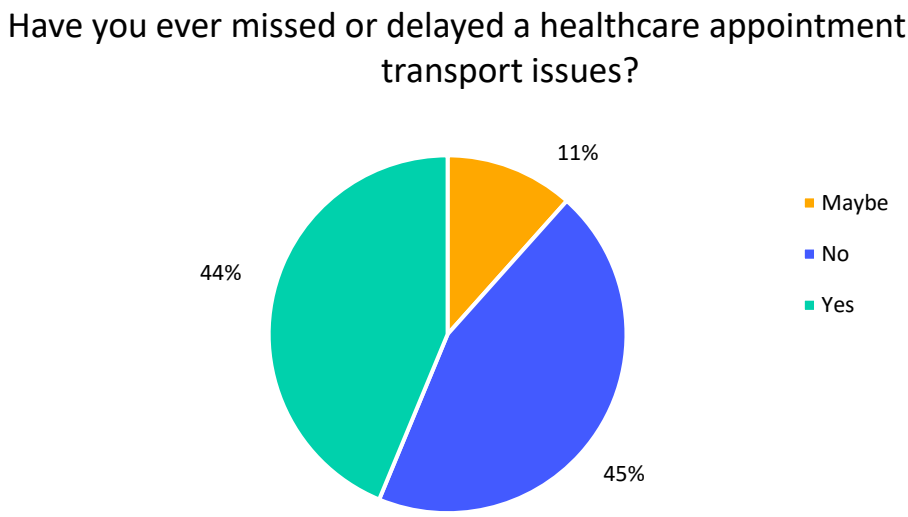


Figure 60: Missed appointments

Effect of transport costs on attendance

Most respondents in NHS Fife stated that transport costs do not affect their decision or ability to attend healthcare. However, a notable minority reported that costs either do affect or sometimes affect their attendance. This minority rises by 12% when only considering those who don't have a free bus pass. This indicates that while cost is not a barrier for most patients in Fife, it remains a significant issue for a proportion of service users.

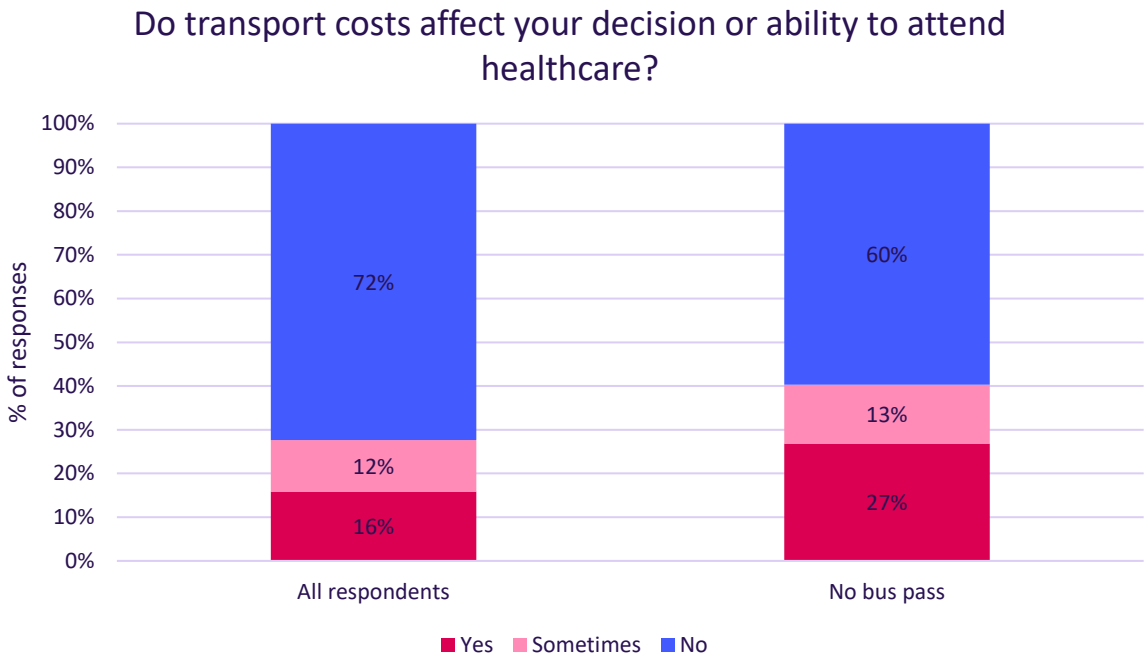


Figure 61: Reason for missed appointment

Cost of the most recent healthcare journey

Among NHS Fife respondents, most reported that their most recent return journey to a healthcare appointment did not cost anything. Where costs were incurred, the majority spent under £10, with the largest proportion paying under £5. Smaller numbers reported spending between £11 and £20, and only a limited number incurred costs above £20.

A small proportion were unsure or unable to remember the cost. Overall, most journeys are low-cost, but a minority face higher travel expenses.

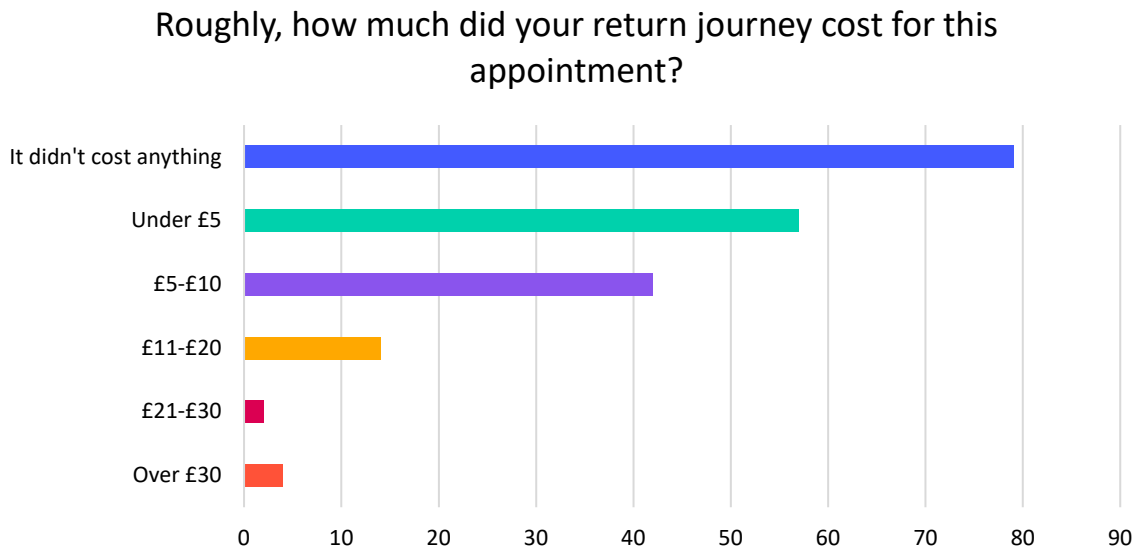


Figure 62: Cost of journey

How people find travel information

In terms of ease of finding and understanding travel information, most respondents said this is possible “most of the time”. A sizeable proportion reported that it is only “sometimes” easy, while fewer said it is “always” easy. A notable minority reported that they rarely or never find the information easy to access or understand.

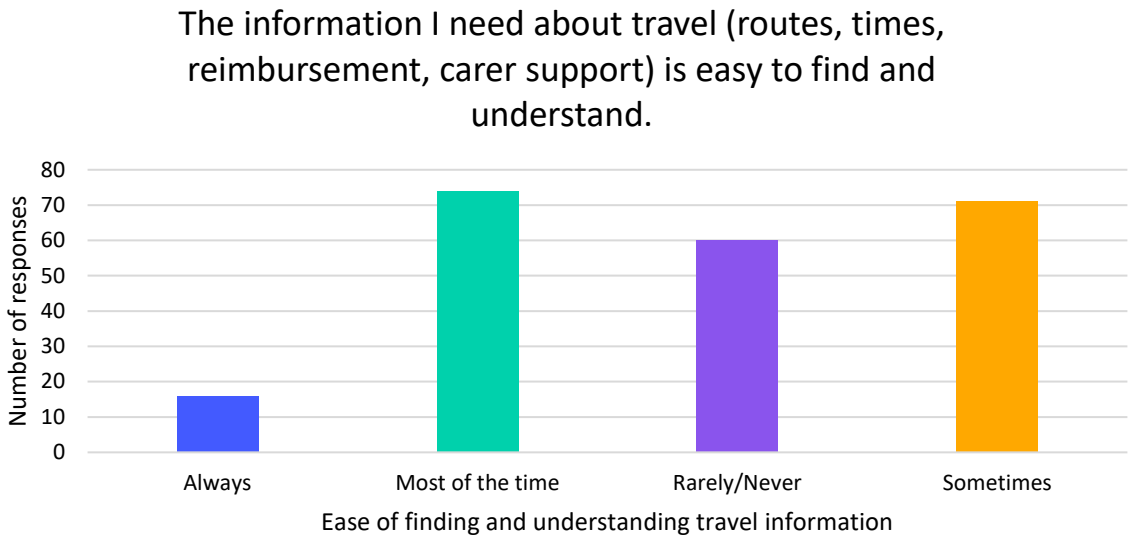


Figure 63: Digestible information

NHS Fife respondents most commonly relied on digital mapping tools such as Google or Bing Maps to find travel information, followed closely by online resources such as Traveline and NHS websites. Information included in patient letters was also an important source. Word of mouth and personal knowledge played a moderate role, while community transport providers, NHS staff advice and local bus apps were used by fewer respondents.

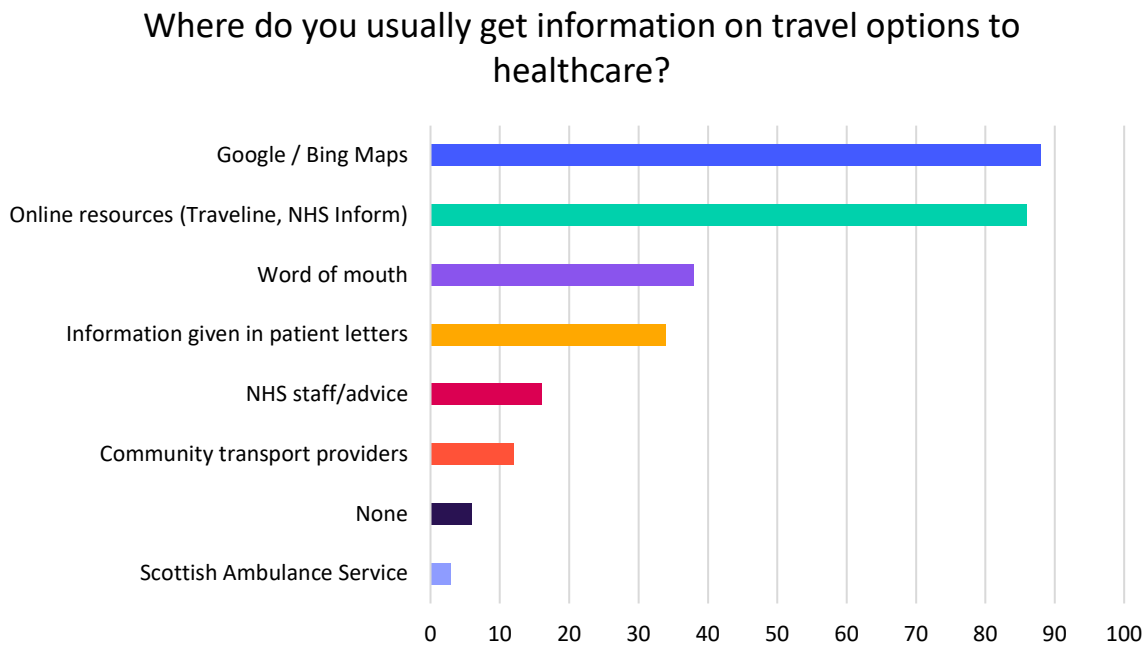


Figure 64: Where do you get your information?

Digital confidence in planning healthcare travel

Overall digital confidence among NHS Fife respondents is high. Most described themselves as either very confident or fairly confident in using online tools to find travel information or book transport. Smaller numbers were not very confident, and only a small minority were not confident at all.

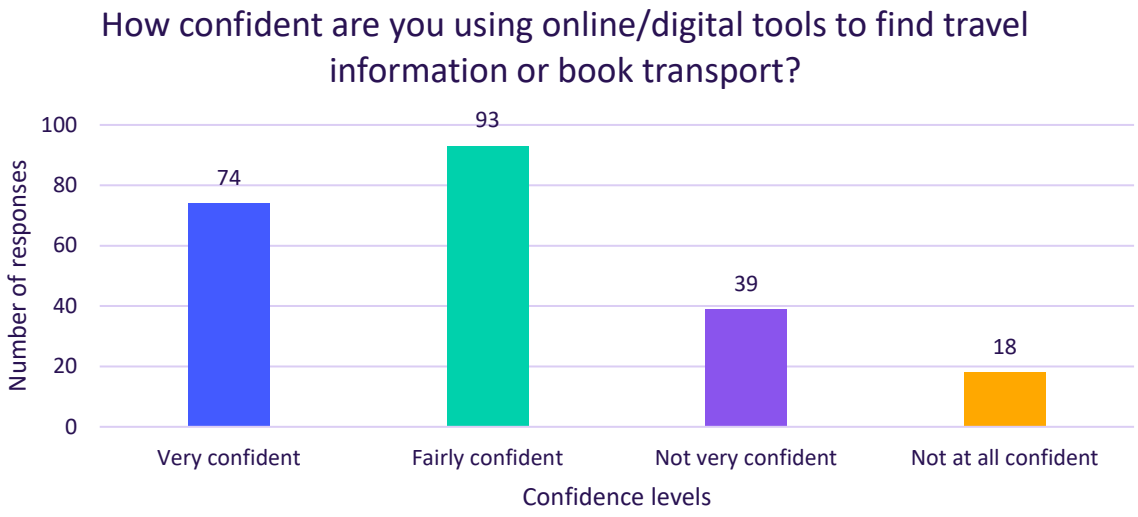


Figure 65: Confidence online

In practice, most respondents usually use digital tools for travel information or booking within NHS Fife. A substantial proportion use them sometimes, while fewer reported that they rarely or never use digital tools for this purpose.

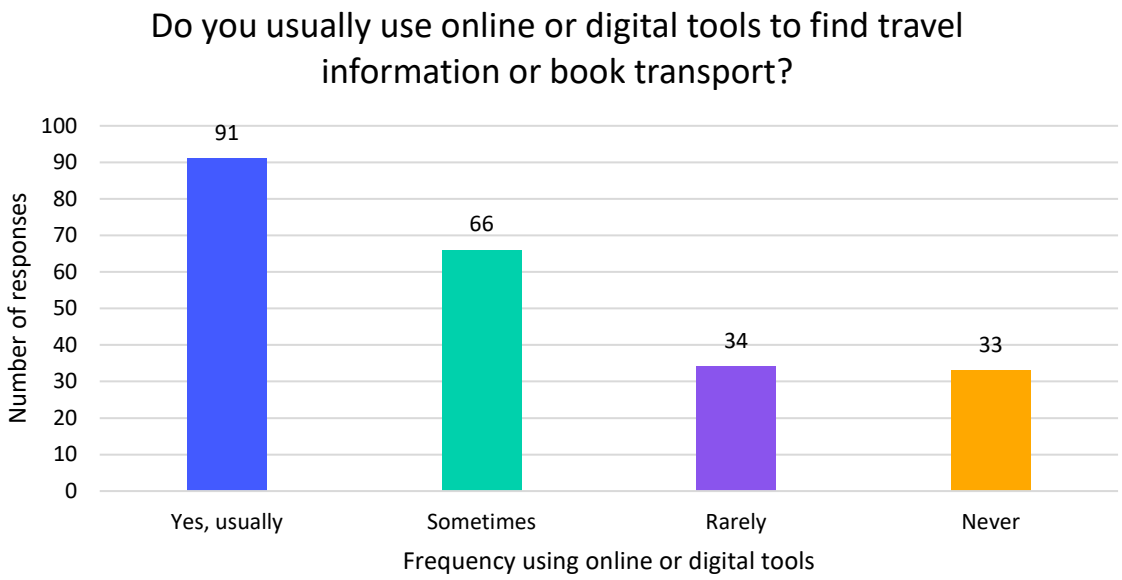


Figure 66: How do you use online tools

Severity of transport barriers

Within NHS Fife, the most commonly identified barrier was the lack of direct public transport routes to healthcare services. Difficulties with parking and poor connections between different transport services were also significant issues. Problems with coordination and information across agencies were reported by a moderate number of respondents. Cost, availability of suitable services, and support for carers and disabled users were identified as additional barriers, though by smaller proportions of respondents.

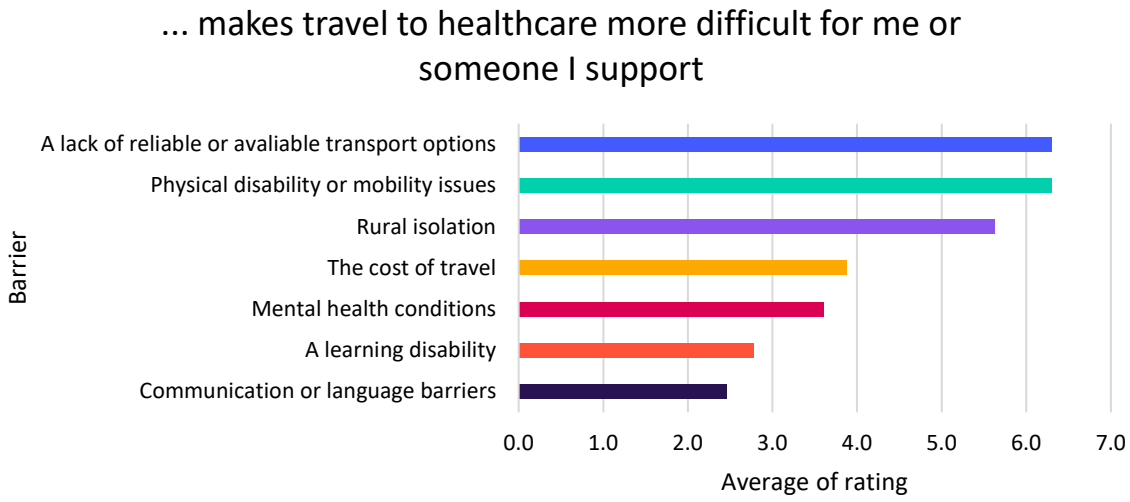


Figure 67: Difficulties with travel

Which group experience the greatest barriers

The data shows that disabled respondents in NHS Fife experience all transport barriers more frequently than non-disabled respondents.

The most significant barrier for both groups is a lack of reliable or available transport options, but this is more pronounced among disabled respondents. Physical disability or mobility issues are also a major barrier for disabled people, while this is far less significant for non-disabled respondents.

Rural isolation affects both groups, although it is again more commonly reported by disabled respondents. The cost of travel is a moderate barrier for both groups, with similar levels of impact.

Barriers linked to mental health conditions, learning disabilities, and communication or language barriers are reported at lower levels overall, but remain consistently higher for disabled respondents than for non-disabled respondents.

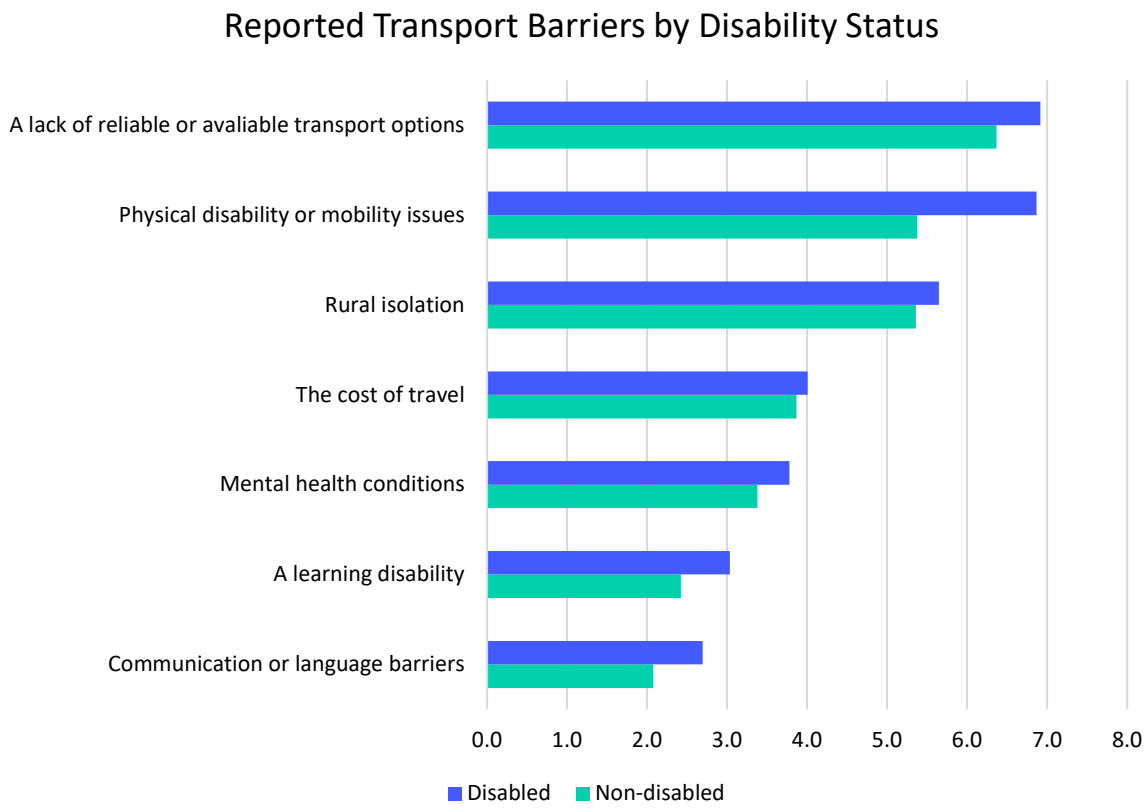


Figure 68: Transport barriers

What improvements people want

The most popular option among respondents was demand responsive transport, indicating strong demand for flexible local travel services. There was also high support for remote consultations and hospital or clinic transport services, suggesting that alternatives to independent travel are widely welcomed.

A moderate number of respondents would consider using shared taxis, community car schemes and digital booking tools. Only a small proportion said they would not use any of these options. Self-driving vehicles attracted the least interest and are not seen as a current priority.

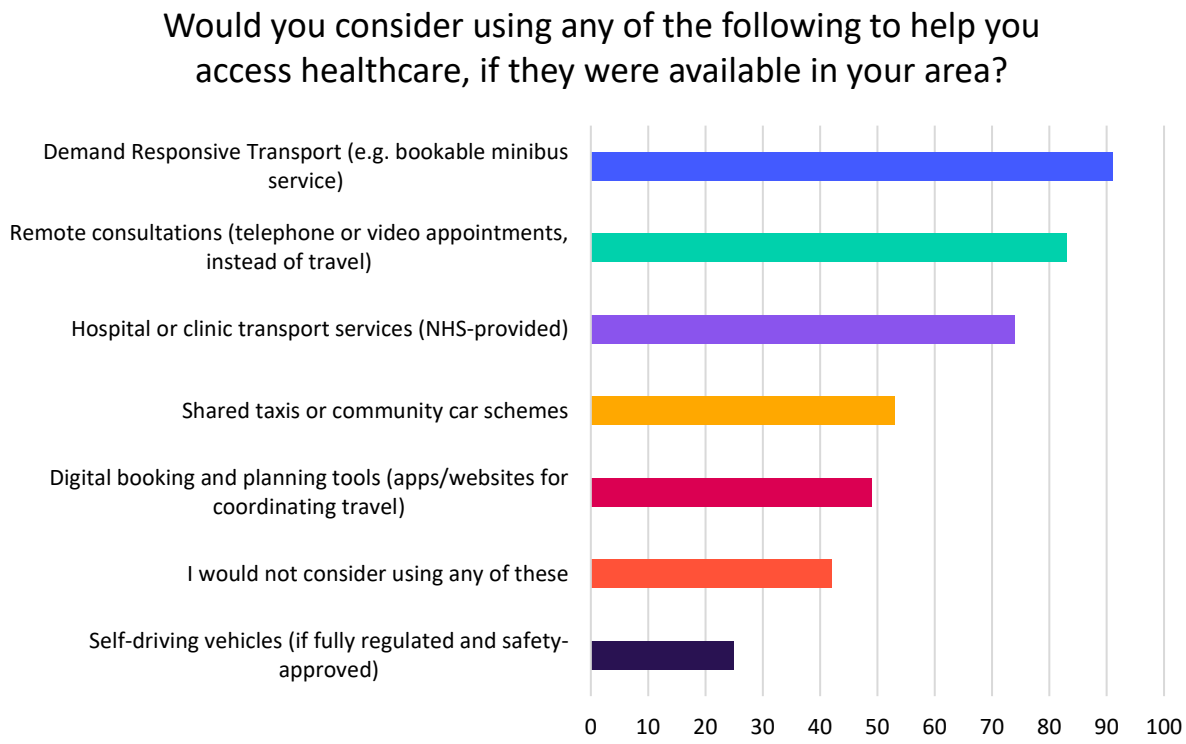


Figure 69: What would help access healthcare

Qualitative insights: Lived experience of travelling to healthcare

Transport availability, accessibility and distance

Across NHS Fife, respondents frequently described limited, indirect and infrequent public transport as a major barrier to accessing healthcare. Many reported that local bus services have been reduced or removed altogether, leaving some communities with no direct public transport to hospitals or GP services. This was particularly evident in places such as Limekilns and Tayport, where residents reported being unable to reach Fife hospitals without travelling via Dundee or relying on taxis. One respondent noted that

> "The only bus we now have taken us out of the county to Dundee, so [we are] unable to attend Fife-based hospital appointments."

Journey length was a consistent problem, with public transport trips often taking significantly longer than the equivalent car journey. Respondents described journeys of over an hour for appointments that would take 20 minutes by car, and in some cases requiring multiple bus changes. Travel to more specialist services was particularly challenging, with one individual reporting that reaching Perth from Tayport required "6 buses". This level of complexity was described as a deterrent to attending appointments.

Service frequency was also a prominent concern. In parts of rural and semi-rural Fife, buses run only once an hour, making it difficult to match appointments with available services. One respondent noted:

"Only one bus an hour goes near to the GP surgery and hospital"

Centralisation of services increased the travel burden further. Several respondents highlighted the shift of specialist services to Victoria Hospital, Kirkcaldy, describing journeys as time-consuming and expensive:

"Outrageous that we have to travel so far for most services at the Victoria Kirkcaldy"

A lack of accessible alternatives was also evident. Patient transport services were not always available or practical, with one respondent stating

"We don't use patient transport because no one has time for that"

Others reported living too far from bus stops for public transport to be a realistic option, particularly for those with mobility issues.

Finally, concerns about the comfort, safety and confidence of bus travel were raised, with one respondent noting that

"Confidence using buses is low as they can be uncomfortable and behaviour of fellow passengers can be off-putting"

Lack of direct routes and reduced bus services[25]

Respondents across NHS Fife reported that reductions in bus services, indirect routes and unreliable timetables are making it increasingly difficult to reach healthcare, particularly for those without access to a car. These issues affect both same-day urgent care and planned appointments and were most acute in rural and semi-rural areas.

Several participants described how previously frequent services have been reduced, leaving them with infrequent or unreliable options. One respondent explained that a service that had run every 30 minutes was changed and now

"Does not always run… it is hit and miss"

meaning they faced a 35-minute walk to their GP surgery if no lift was available. Others reported buses being withdrawn entirely due to driver shortages, with little notice given to passengers:

[25] https://tinyurl.com/bddpsysa

"Buses are often late or don't turn up at all… this information is not communicated to people waiting at stops."

Long, indirect journeys caused by poorly connected services were common, with many planned appointments requiring two or three buses each way. Some respondents described hospital trips taking most of the day, including one case where a 40-mile journey involved multiple bus changes and took over seven hours in total. These lengthy journeys were described as physically exhausting, painful and highly stressful, particularly for those with long-term conditions.

The unreliability and limited frequency of bus services also led to missed or cancelled appointments. Respondents described having to book specific appointment times to match infrequent bus schedules, only to cancel when services ran late. One participant noted that their GP surgery was only ten minutes away, but because the bus ran once an hour and was often late, they had cancelled several appointments as a result.

For many respondents, the lack of direct, reliable and well-timed public transport made attending healthcare appointments difficult to plan and sustain. This was particularly evident for routine hospital outpatient, GP and community-based appointments, where infrequent services, long walks to bus stops and unreliable timetables increased the risk of lateness or cancellation. Respondents described cancelling appointments when buses operated only once an hour or failed to arrive, and others highlighted the difficulty of aligning fixed appointment times with limited service availability.

"Public transport options are poor where I live, nearest bus stop is 0.7 miles and buses are only once an hour so getting to Markinch (GP/pharmacy), Leven (optician) or Kirkcaldy (dentist) in time for appointment would be very difficult."

Parking and reliance on private transport

Across NHS Fife, respondents consistently reported that poor hospital parking is a major barrier to accessing healthcare and is a key reason why many feel forced to rely on private cars rather than public transport. Parking problems were reported at both GP surgeries and hospitals but were most frequently associated with Victoria Hospital in Kirkcaldy and Ninewells.

Lack of available spaces, particularly disabled parking, was a recurring issue. Several respondents with Blue Badges stated they were still unable to secure suitable parking, with one noting: "Despite having a blue badge, I rarely get a disabled space." Others described having to arrive 45 minutes to an hour early just to find parking, adding significant stress to already worrying appointments. One participant described the experience as a

"Stressful nightmare"

Parking difficulties also undermine patient safety and carer support. Some carers reported needing to drop off vulnerable patients before searching for a space, leaving them temporarily unsupported. One respondent explained:

"I can't get parking, therefore have to abandon him, try find parking, hope he can get to his appointment safely without my support."

For wheelchair users, parking problems are compounded by poor accessibility from remote parking areas, including uneven pavements and long walking distances. One respondent noted that even when council parking is available, surfaces make it:

"Difficult to push a wheelchair over uneven surfaces."

The emotional impact of parking stress was particularly evident for patients undergoing major treatment. One respondent stated clearly:

"Parking at hospital causes huge stress to cancer patients."

Others described driving in circles for extended periods due to lack of spaces and unsafe parking conditions.

In rural areas and during evenings, limited public transport further increases reliance on private cars, intensifying pressure on already constrained hospital parking. One respondent noted that travelling to Kirkcaldy and then trying to park late at night is:

"So stressful… when there is no public transport."

Accessibility and health-related needs

Respondents across NHS Fife highlighted that physical accessibility, health conditions and caring responsibilities significantly limit how people can travel to healthcare. For many, public transport is either difficult or impossible to use due to mobility needs, treatment requirements or caring duties.

Several participants reported that public transport is physically inaccessible, including issues such as steep steps on coaches and insufficient time for those with mobility difficulties to board and disembark safely. One carer explained that buses are:

"Restrictive for the person I care for because they need more time to react, stand up, walk down… before the bus can move off."

For people with disabilities or complex health needs, public transport is often not a viable option at all. One respondent stated clearly:

"Public transport isn't an option, travel by car is the only option due to disabilities."

Another added that a car is essential when caring for an elderly relative with "mobility, sight and dementia issues."

Caring responsibilities further restrict travel options. Carers described situations where they must make long, complex journeys when the usual driver becomes the patient. One respondent noted:

> "I am carer for my husband who is the driver. So, if he's the one in hospital, I have to get two buses to get there."

Others described the physical impossibility of dropping off dependants and then parking separately due to disability.

Limited access to clear transport information also creates accessibility barriers. Some respondents highlighted that timetables are often only available online, which excludes those without smartphones:

> "Bus or train timetables are in general only accessible using a smart phone."

Reductions in local bus services disproportionately affect those with limited mobility, particularly when walking to alternative stops is not possible. One participant explained that when a nearby service is unavailable, they are simply unable to reach appointments due to their limited walking ability.

Stress, cost and limited alternatives

Many respondents described significant financial and emotional strain linked to the cost of travel and the lack of affordable alternatives for getting to healthcare appointments across NHS Fife.

Transport costs are a major barrier, particularly where taxis are required for part of the journey. One respondent explained that travelling to Kirkcaldy often means:

> "a taxi for at least one part of the journey which costs £40–£50".

while others stated simply that "cabs are extremely expensive." Even accessing GP services can involve high costs, with one respondent noting:

> "Our GP surgery is now based in the next town requiring £20 taxi fares to attend."

Fuel costs were also highlighted as a constraint, particularly for those travelling long distances by car.

The cost of time is equally significant, with many people losing income to attend appointments. Respondents described

> "Hours lost in pay from time taken off work"

and the difficulty of attending appointments that are only available during working hours. One person said:

"I work full time; I avoid going to the doctor's because they are only available during working hours."

Travel time and costs combine to create additional pressure when appointments are limited to weekdays.

Poor communication and information barriers add to stress and undermine confidence in the transport system, particularly for disabled passengers. One respondent who is sight-impaired described being left behind during a replacement bus service despite explaining their needs, with the driver and colleagues:

"Walking past me, not saying a word"

and only learning the bus was leaving when strangers intervened. This experience highlights gaps in disability awareness and service communication.

At hospital sites, poor signage and wayfinding further increase anxiety at already stressful times. One parent described arriving for an ENT appointment at Victoria Hospital in Kirkcaldy but being unable to identify the correct building, noting that:

"Nothing about that building told me we were in the right location"

and that small fixes to signage could make a major difference.

Summary of insights for NHS Fife

The evidence from NHS Fife highlights a pattern of broadly accessible local primary care, contrasted with significant challenges accessing secondary care, especially for residents of rural, coastal and semi-rural communities. These challenges arise from settlement patterns, uneven public transport coverage, reduced bus service frequency and the centralised location of specialist hospital services.

Key themes emerging from the data and lived experience

↘ Good access to primary care, but long and complex journeys for hospital-based care

Most respondents reach GP surgeries and pharmacies within 15 minutes, indicating strong local provision. However, journeys to Victoria Hospital and other specialist centres often exceed 60 minutes, particularly for residents in North Fife, East Neuk and more rural inland settlements. These longer trips frequently involve multiple bus changes and extended waiting times.

↘ High reliance on the private car, driven by limited and indirect public transport

Car use is the most common way to reach healthcare across Fife. Public transport plays an important role for those without car access, but respondents consistently described indirect routes, reduced frequencies and unreliable services. Some communities, such as Limekilns and Tayport, reported losing direct links to Fife hospitals, with services now routing via Dundee.

↘ Public transport reliability issues contribute to missed and delayed appointments

Over one third of respondents reported missing or postponing appointments due to transport issues. The most common reasons included delayed or cancelled buses, traffic congestion, long walking distances to stops and difficulty aligning appointment times with hourly services.

↘ Parking pressures at major hospitals create significant stress and reinforce car dependency

Victoria Hospital in Kirkcaldy was repeatedly described as difficult to access by car, with respondents reporting long search times, limited disabled parking and high stress levels, particularly for older patients and those undergoing major treatment. Poor accessibility from distant parking areas further affects wheelchair users and carers.

↘ Disabled people and those with mobility or health-related needs face the greatest transport barriers

Respondents with disabilities described public transport as physically inaccessible, unpredictable or too demanding for their condition. Many stated that the car is the only viable mode. Carers also reported challenges when they become the patient or must accompany relatives with complex needs.

↘ Transport costs remain a barrier for a minority, especially in rural areas

While most respondents did not report cost-related barriers, those reliant on taxis faced significant expense. Single journeys to Kirkcaldy costing £20–£50 were commonly reported, alongside lost income due to time taken off work.

↘ Strong demand for flexible, coordinated and affordable alternatives

Respondents expressed the highest support for demand-responsive transport, followed by improved direct public transport routes, better coordination between services and expanded hospital transport provision. Clearer travel information and enhanced support for disabled people and carers were also priorities.

NHS Borders – evidence summary

Area overview:

NHS Borders covers the Scottish Borders Council area and is characterised by a predominantly aging population. It is the least populus Health Board in the SEStran region and most rural in nature. Major towns include Galashiels in the centre of the authority (connected by rail to Edinburgh), Hawick in the South, Peebles and West Linton in the West and Eyemouth on the East coast.

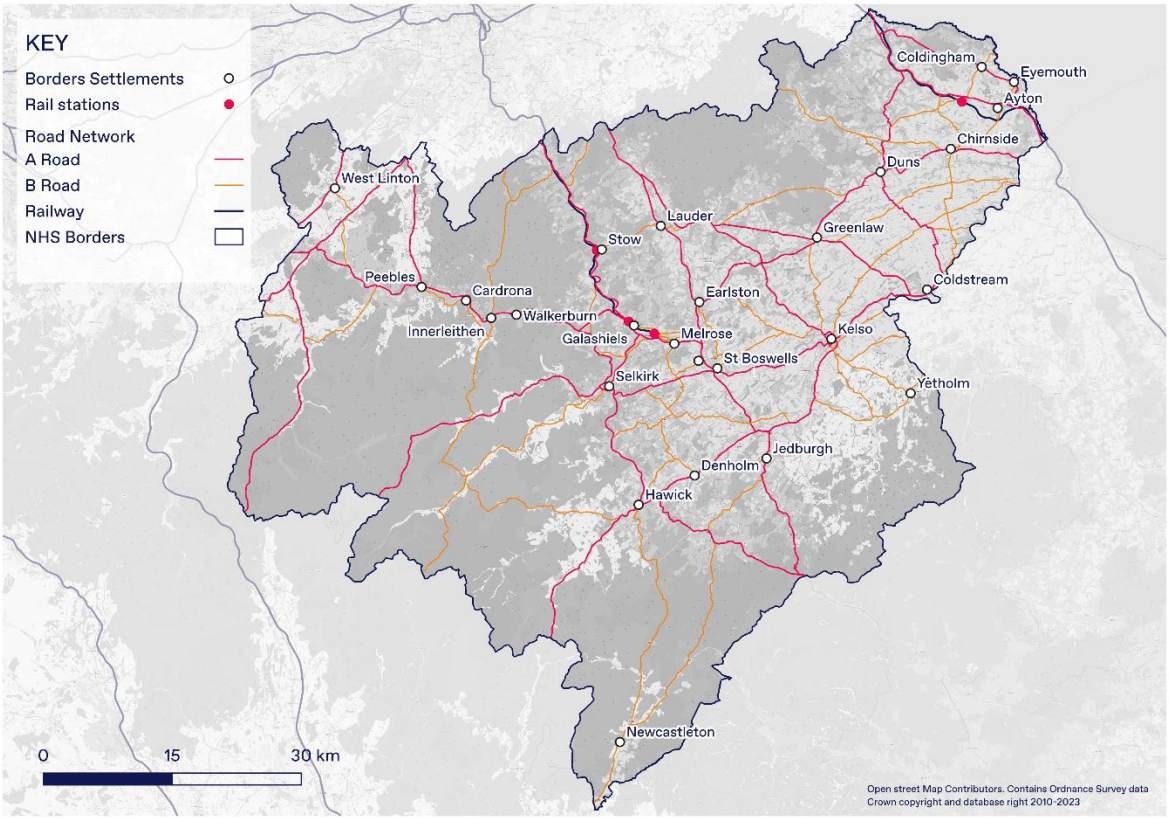


Figure 70: Border settlements

The most significant hospital in the area is the Borders General Hospital in Melrose with other community and smaller hospitals in Peebles, Hawick, Kelso and Duns.

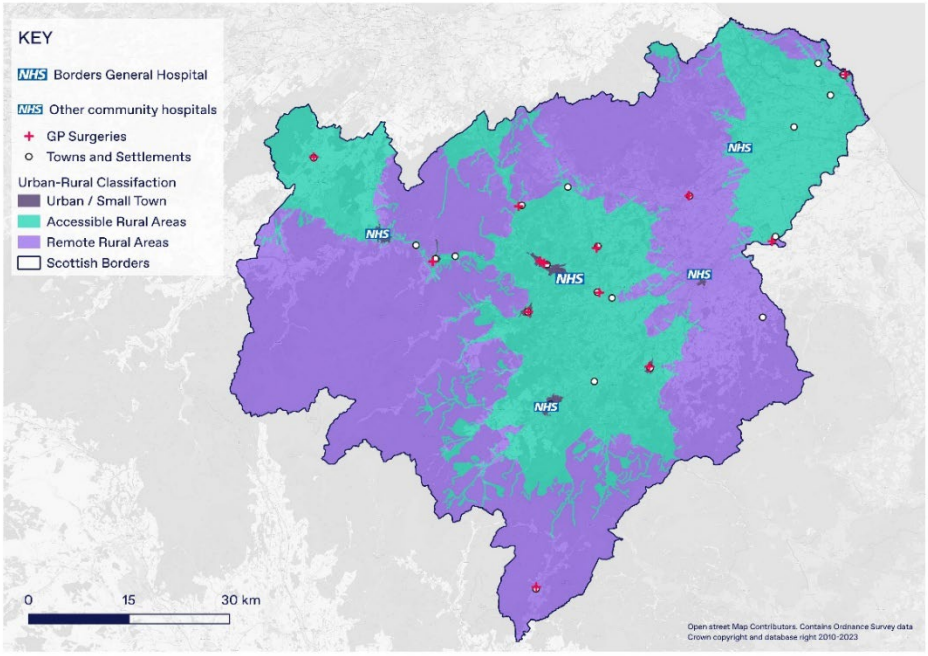


Figure 71: Spread of facilities

Primary healthcare, including GPs, is generally easier to access with most towns having a local GP surgery or health centre. However, a few settlements over 1,000 population lack a dedicated GP facility within 2 miles, for example, Chirnside, whose branch surgery of Merse Medical Practice has closed.

Access to the Borders General Hospital (BGH) is the most pressing issue for Transport to Health in the Borders. Accessing treatment in the BGH from towns like Newcastleton, Hawick, Eyemouth, Peebles or West Linton can prove difficult. This is acutely felt for those living in the rural areas and villages surrounding these settlements. For towns to the West and South of the BGH, travelling to appointments often require at least one change before reaching the hospital. This was a common issue for those living in Peebles and Selkirk. The journey time to the BGH from 9:30AM on 08/12/25 as well as number of buses required to reach the hospital has been mapped below.

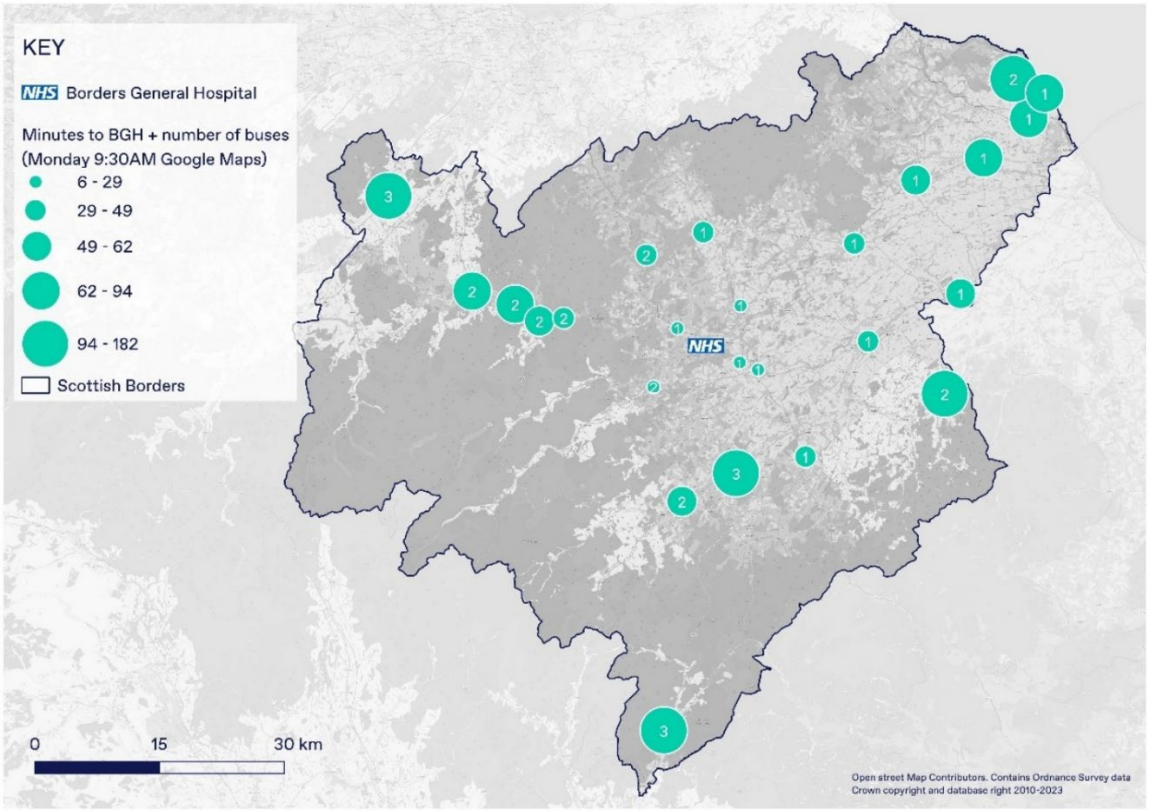


Figure 72: Minutes taken to reach the BGH and number of buses taken at 9:30AM 08/12/25 via google maps

It can be seen in Figure 58 that the requirement to change at Galashiels Transport interchange for towns to the West and South (e.g. Innerleithen 61 minutes) contributes significantly to increased journey times as opposed to towns a similar distance away in the East (e.g. Kelso 40 minutes).

In addition to travel to healthcare within the Scottish Borders many secondary and tertiary services are only available in major hospitals like the Western General and Royal Infirmary in Edinburgh, St John's in Livingston and in some circumstances hospitals in Glasgow. The Western General Hospital on the North side of Edinburgh being the designated oncology treatment facility for the Scottish Borders is a theme in survey responses.

Figure 73 shows a much smaller percentage of the Scottish Borders population resides in the 20% most deprived data zones than the Scottish average. Only 6% of the population of the Scottish Borders lives areas in the most deprived quintile.

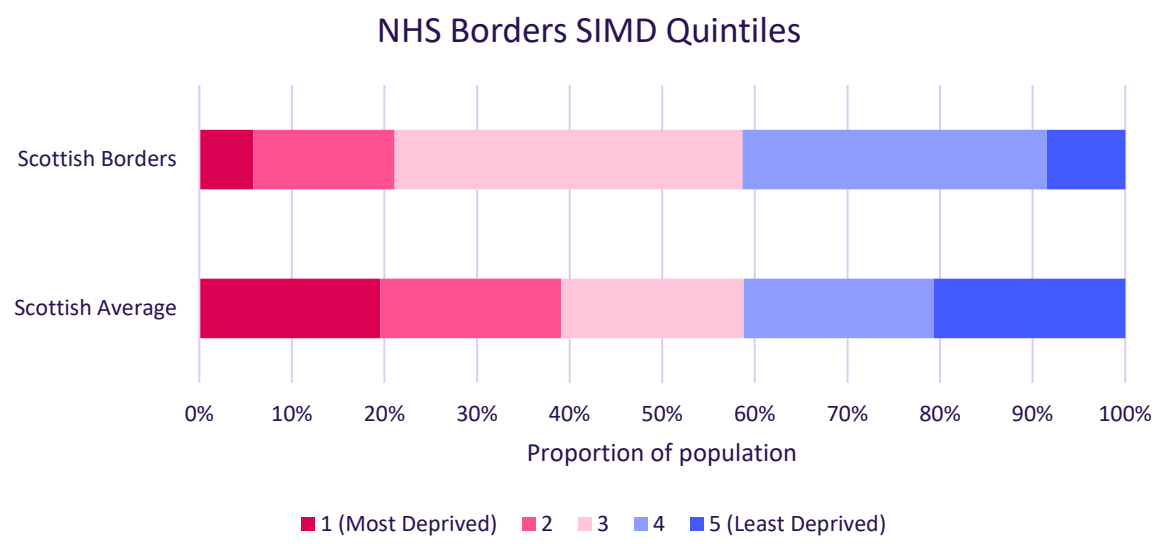


Figure 73: Proportion of NHS Borders population in each SIMD quintile

Respondent characteristics

Survey respondents from the Scottish borders are less likely than average to have access to at least one car. This differs from the majority of health boards where responses were skewed in favour of those with car access.

Survey respondents from the Scottish Borders were not more likely to be older than survey respondents overall. However, the overall 2022 census population of the Scottish Borders skews older with 34% being over 60 years old compared to a SEStran average of 26% over 60 years old.

Similar to other Health Boards, Borders respondents were more likely to have a long-term health condition or disability and more likely to provide unpaid care.

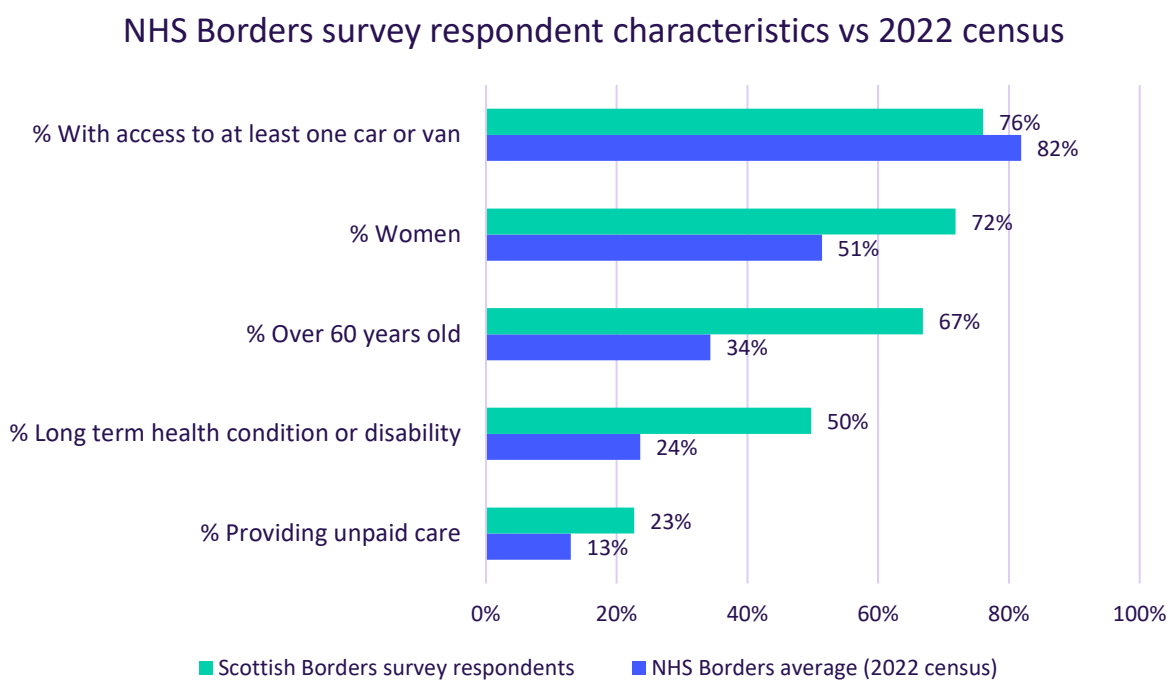


Figure 74: NHS Borders survey respondent characteristics compared to general Scottish Borders population via the 2022 census

Patterns of healthcare use

In the Borders many people engage with a healthcare on a high frequency basis:

- → 70% use pharmacies at least monthly
- → 36% go the GP at least monthly
- → 21% go to outpatient (day) hospital appointments at least monthly

Dentist appointments are fairly frequent, usually once every few months, while optician appointments are less frequent, usually once a year. In-patient appointments are irregular and rarer with 68% respondents reporting not travelling for an overnight stay in a hospital for the last twelve months while the remaining 42% had at least once.

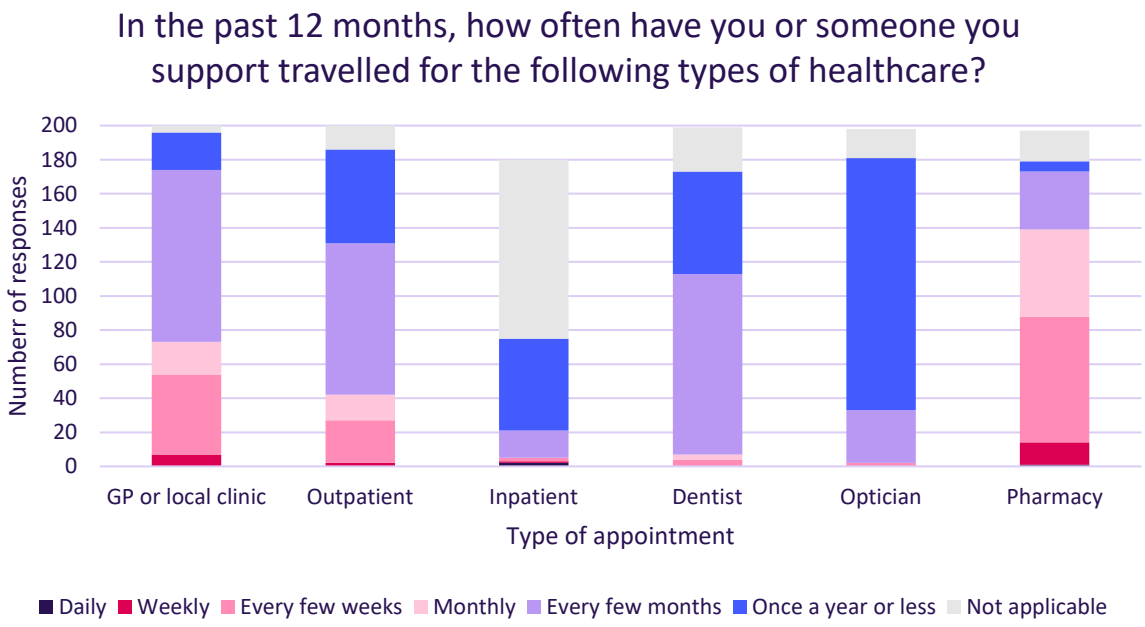


Figure 75: Frequency of healthcare appointment type

How long journeys take

Figure 76 demonstrates the disparity between the much shorter journey times for primary care services such as GPs, pharmacies, opticians and dentists versus the longer journey times for secondary and tertiary care service which occurs at hospitals.

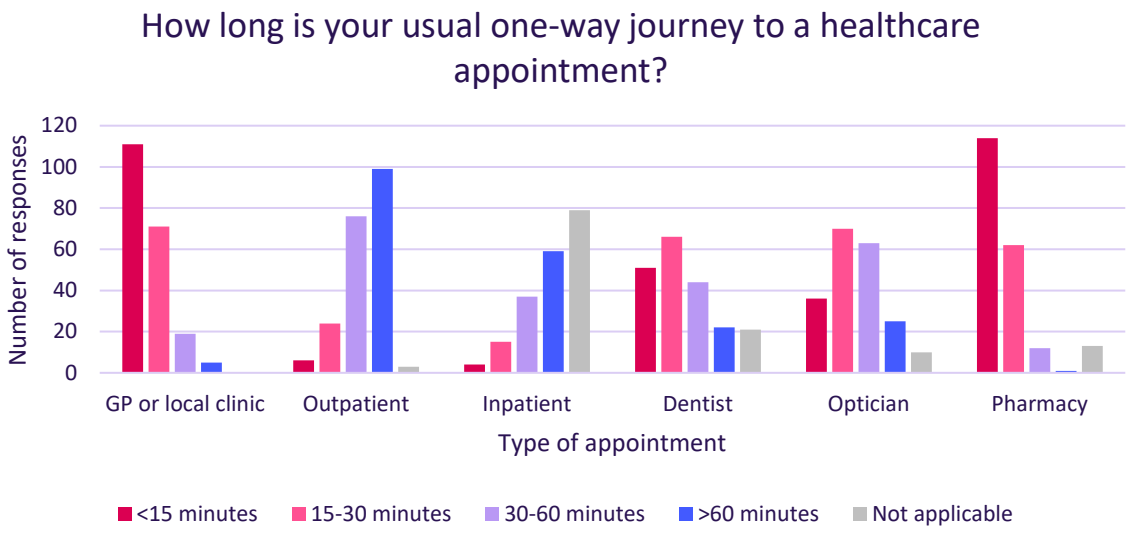


Figure 76: Reported journey time to different types of healthcare appointments

These results align with the spatial distribution of health services in the Scottish Borders. Considering only Scottish Government defined settlements over 500 in population:

- → 27% of settlements don't have a pharmacy or dispenser
- → 38% of settlements don't have a local GP
- → 62% of settlements don't have a dentist

- 85% of settlements don't have a community or general hospital
- The BGH covers all 4,732 km² of the Scottish Borders

How people travel to healthcare

The primary mode people use to access healthcare in the Scottish Borders is driving with 68% of respondents choosing a car either as a driver or passenger. The second most used mode is bus with 24% of respondents choosing it as their main mode with a further 16% using it as a secondary mode. Of the 51 respondents who use the bus as their main mode 21 use the bus despite having access to at least one car in their household.

Fewer respondents picked active travel modes with only 4% respondents selecting walking as their primary mode and 1 wheeling. Active travel was slightly more popular as a secondary mode choice with 6% selecting walking.

Patient and community transport usage are the least popular options reflecting the limited appointments available for patient transport and volunteer shortages amongst community transport options.

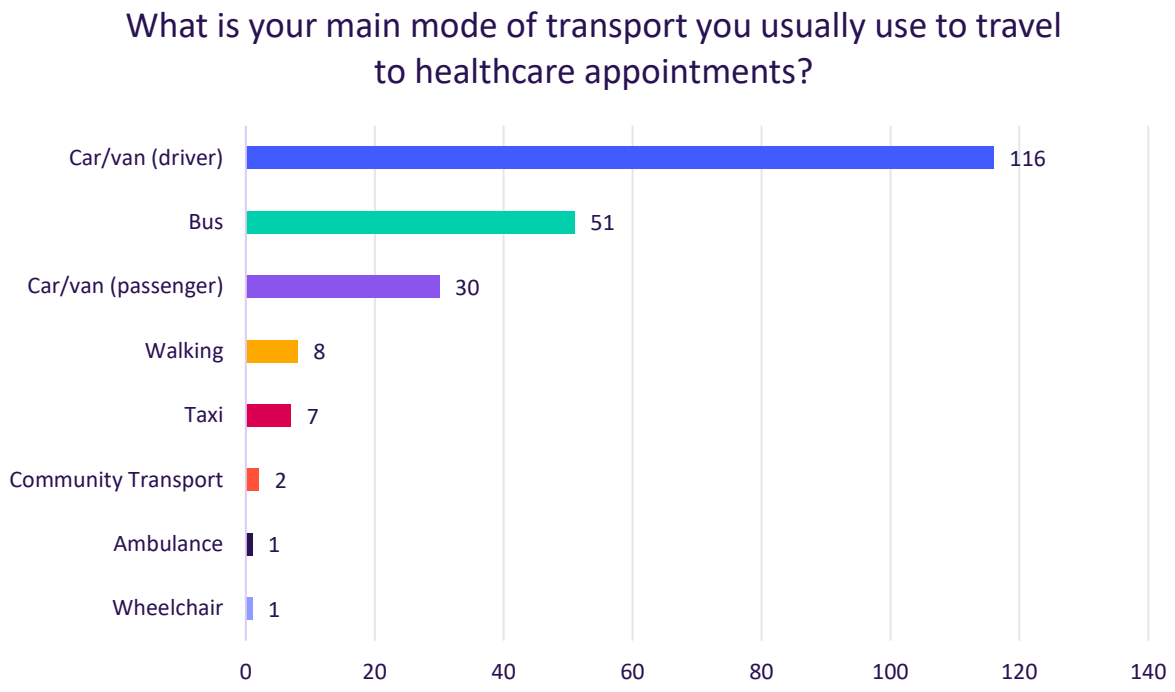


Figure 77: Main travel mode for healthcare appointments

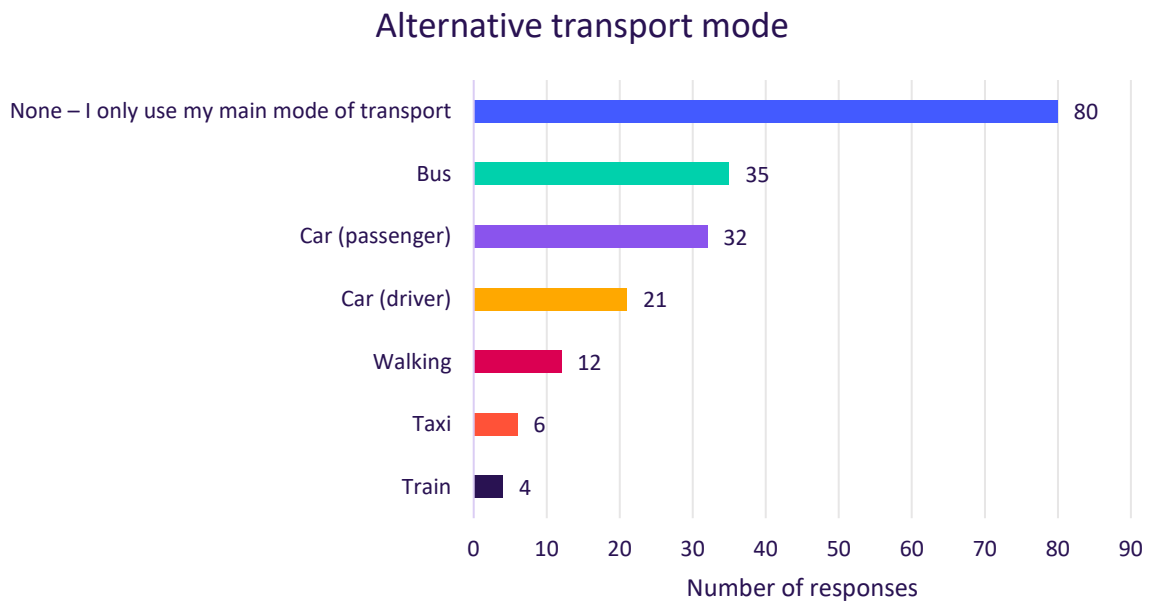


Figure 78: Alternative transport mode for healthcare appointments

Reliability of available transport

Only 26% of respondents characterise their transport choice as 'always reliable' with a further 39% choosing 'usually reliable'. However, when split into the main the main mode of respondents it shows that 82% of 'always reliable' responses come from those who drive a car as their main mode. Those who are usually car passengers (e.g. reliant on lifts) or bus users do not characterise their journeys as 'always reliable'.

Across all modes, the least frequently selected option was 'often unreliable', showing that there is a baseline level of reliability for most respondents.

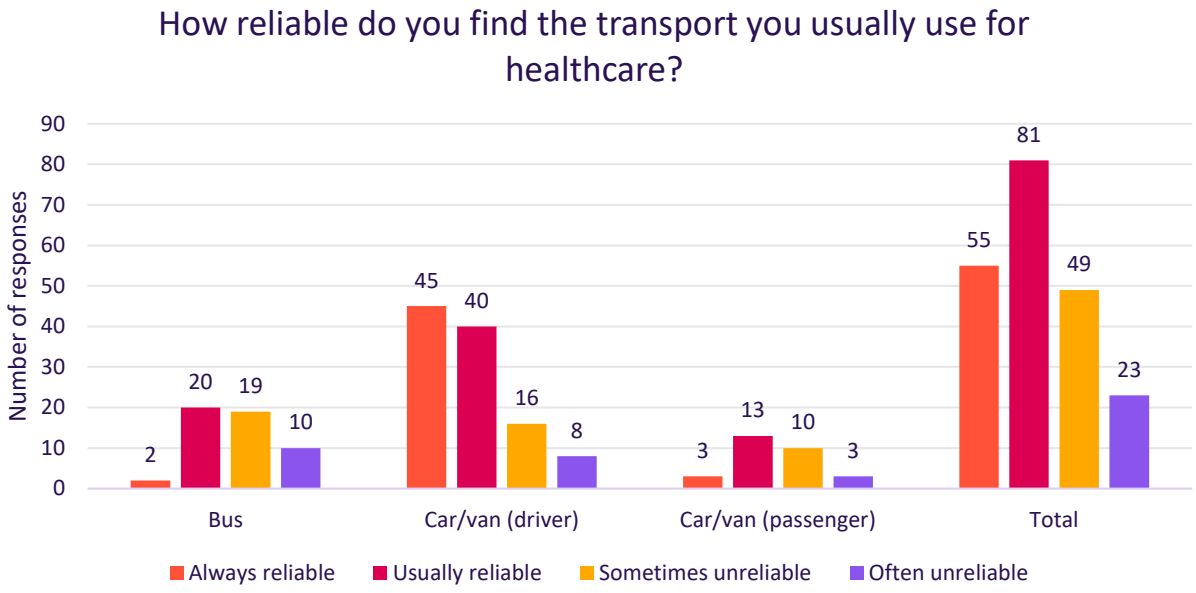


Figure 79: Perception of reliability of transport to healthcare by mode choice

Missed or delayed appointments due to transport

Of respondents, 39% had reported missing or delaying a healthcare appointment due to transport issues. This demonstrates that transport issues play a major role in the reasons for missed appointments.

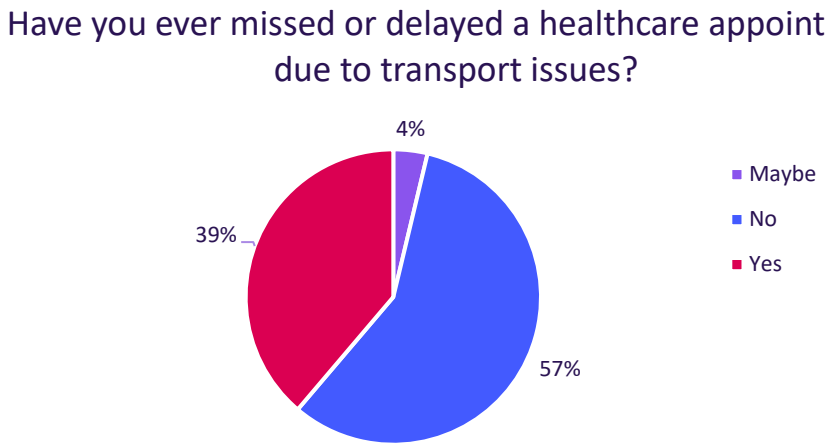


Figure 80: Proportion of respondents who missed or delayed a healthcare appointment due to transport issues

The top reason amongst those who said they had missed or delayed an appointment due to transport was 'Lack of suitable transport options' (45%), and 'poor connections between services' (24%). This reflects that bus service issues are the most common reason for people missing their appointments. This could be a lack of services altogether in their area, a timetable which doesn't suit appointment times, bus stops too far to walk from their origin or destination, long transfer times between services or a range of many more service issues.

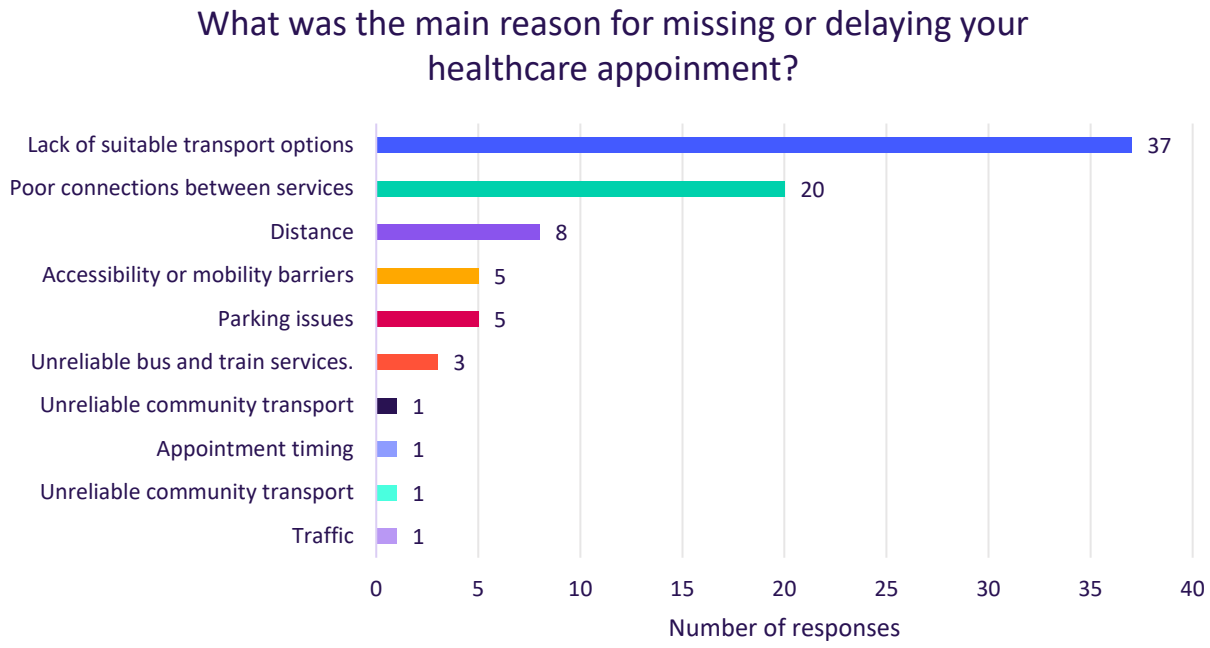


Figure 81: Reason for missing or delaying healthcare appointments

Effect of transport costs on attendance

The majority of respondents reported that transport costs did not affect their ability or decision to attend healthcare. This suggests that poor transport links or the inability to travel is a greater deterrent than cost when it comes to attending healthcare.

When responses are filtered by those who are non-bus pass holders, the proportion who say that costs affect their ability or decision to attend healthcare increases slightly. Those with no car access were even more likely to report transport costs deterring them and those with no car or bus pass were the most likely to report transport costs playing a role. Despite cost playing a lesser overall role in missed appointments, it has a much greater impact on those who do not have access to a private car or free bus transport.

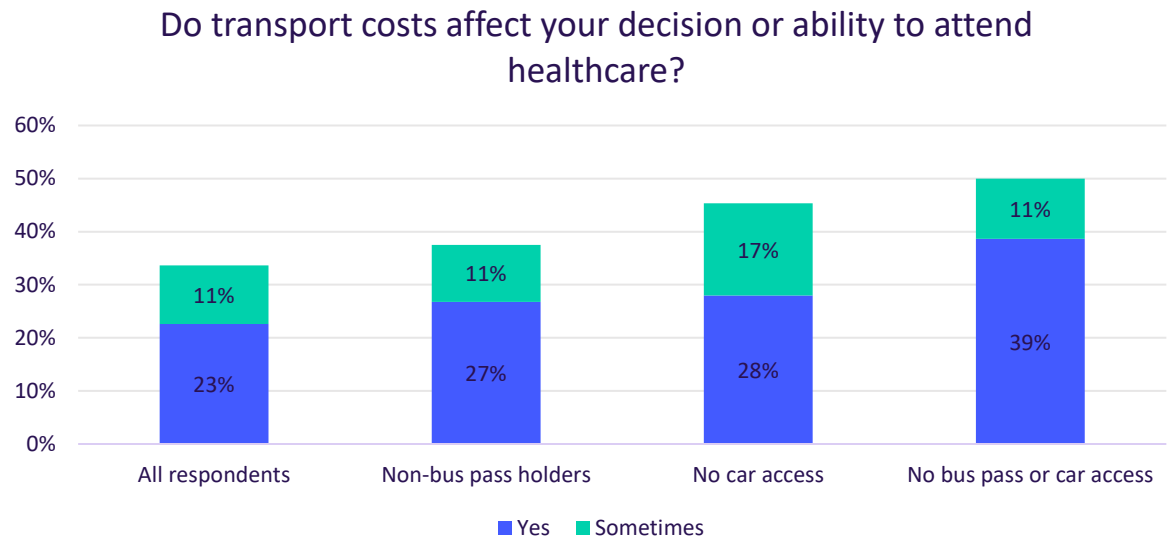


Figure 82: Proportion of respondents who report transport costs affecting their ability to attend healthcare by bus pass holders and car access

Cost of the most recent healthcare journey

The cost of a healthcare journey varies considerably depending on factors like mode choice and distance to hospital.

The most common response was 'It didn't cost anything' at 33%. This category was made up of 49% bus users, likely due to being bus pass holders. Overall, 70% of those who selected their main mode as the bus also reported paying nothing for their most recent healthcare journey. 26% of those who reported paying nothing were car drivers, this may be because they were driving someone else's car without paying for fuel or because they don't perceive driving as a costly activity. A further 12% who reported paying nothing were car passengers.

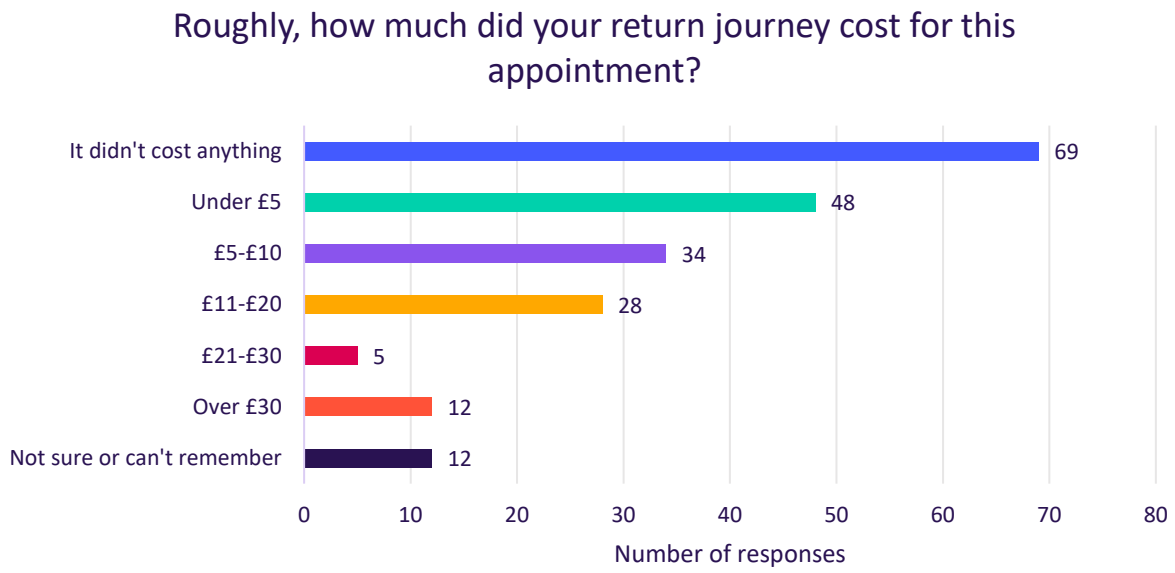


Figure 83: Cost of return journeys for most recent healthcare appointment

23% of respondents reported paying less than £5. 16% of respondents reported paying £5-10 and a decreasing proportion of respondents reporting paying higher amounts.

When considering healthcare costs by appointment type it can be seen that primary care trips to the GP, dentist, pharmacy, or optician rarely cost more than £10 for a return journey, with most respondents either travelling for free or for less than £5.

However, hospital appointments for both inpatient and outpatient can be much more expensive with those who aren't travelling for free (bus pass holders, car passengers etc.). To reach secondary care involves often paying more than £10 per appointment. Taken together 61% of hospital inpatients and outpatients pay at least £5 for a return journey with 40% paying over £10.

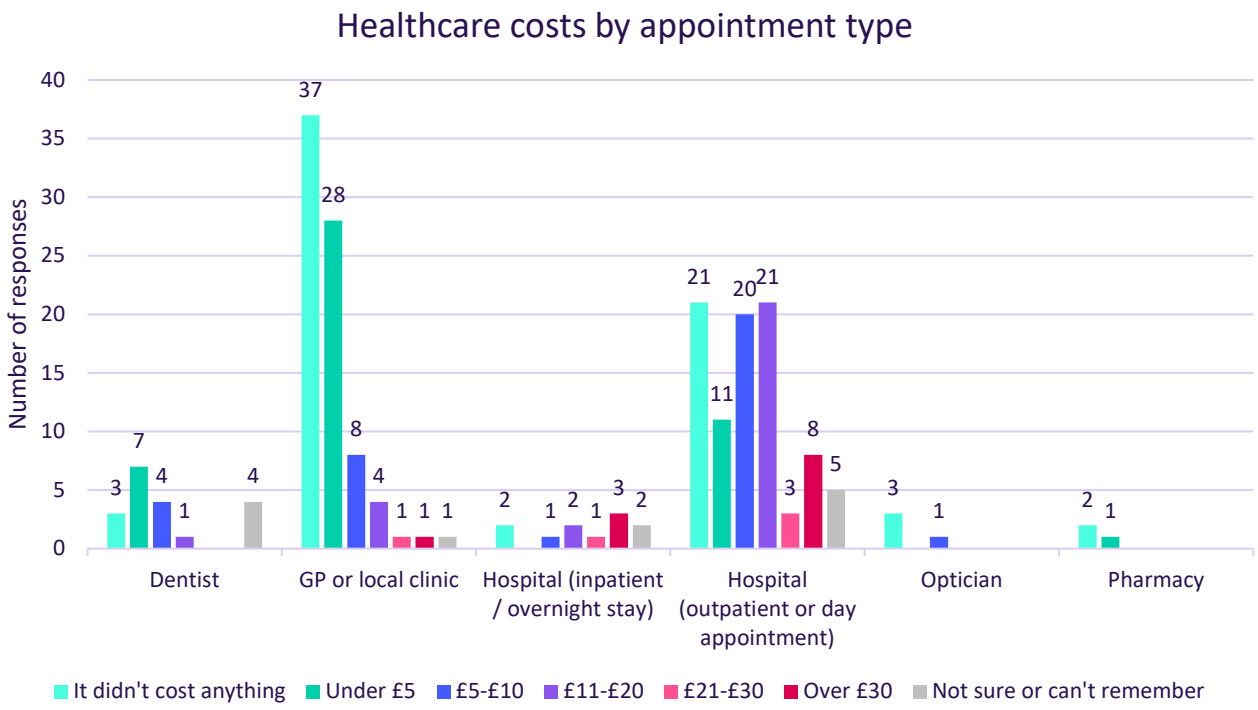


Figure 84: Transport costs by healthcare appointment type

How people find travel information

The most popular way to find travel information is online (68%). 32% using google or Bing maps and 36% using other online resources including Traveline and NHS Inform.

Other popular methods include 'information given in patient letters' (21%) and 'word of mouth' (20%).

Fewer respondents selected receiving information from community transport providers, NHS staff/advice or through the Scottish Ambulance Service.

A large proportion of respondents the 'other' option to specify additional methods they find travel information. Themes that recurred in these responses included those that use their own transport (drive), have local knowledge, expressed that there is lack of information available or that they use other online methods like the Borders Buses App.

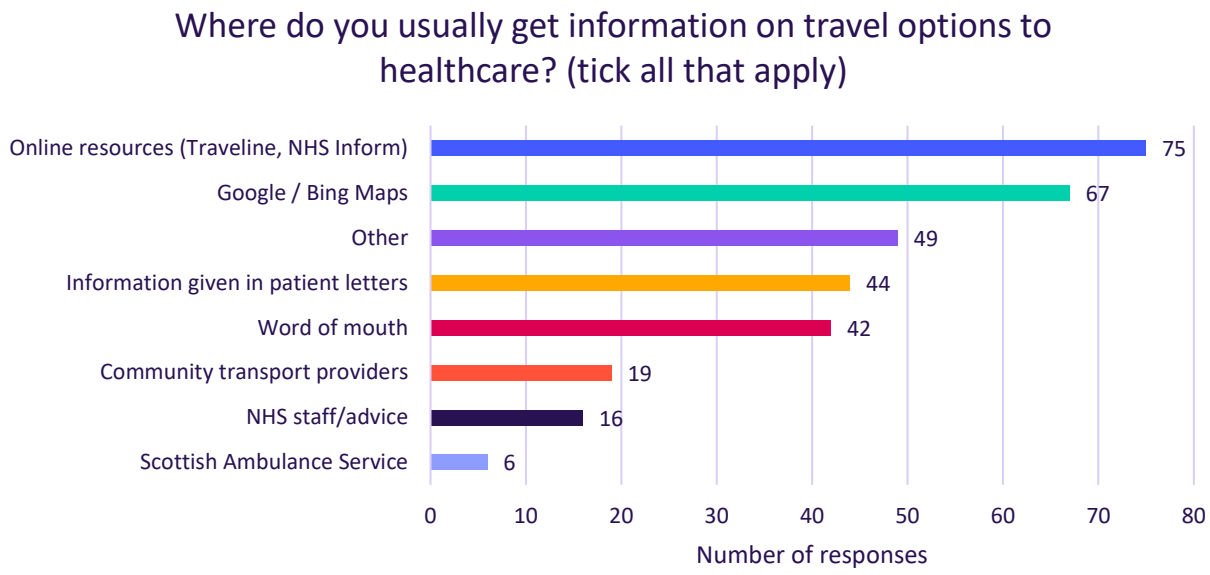


Figure 85: Most popular methods to get travel information for healthcare journeys

Digital confidence in planning healthcare travel

Most respondents where either fairly or very confident using online or digital tools to find travel information.

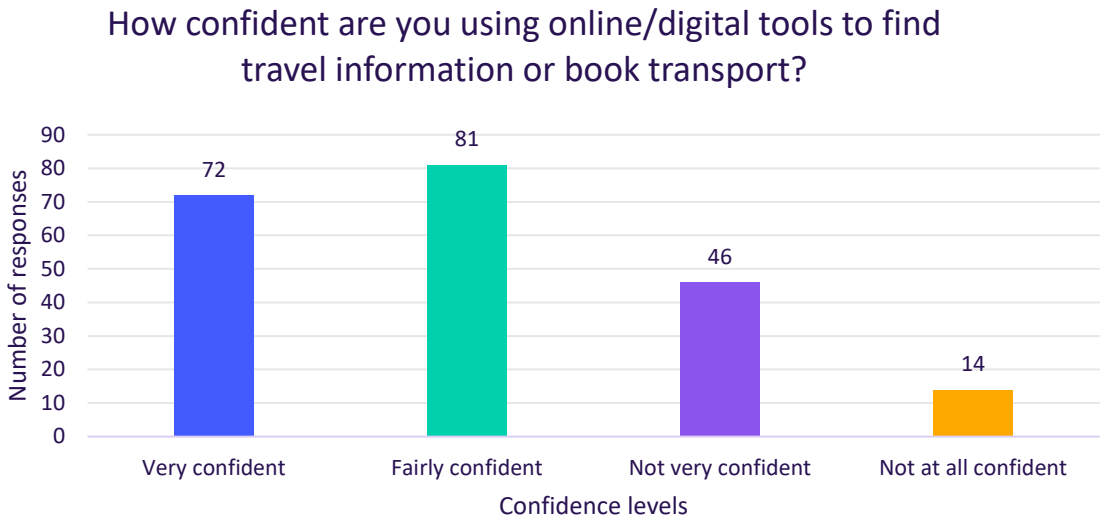


Figure 86: Confidence using online tools to find travel information or book transport

74% of respondents use online or digital tools to find travel information or book transport either 'usually' or 'sometimes'. This demonstrates that online methods are now the primary way people tend to interact with information about transport. However, a small proportion of people report never using digital or online tools demonstrating that off-line options must still be made available. Like physical timetables, information leaflets and phone line services.

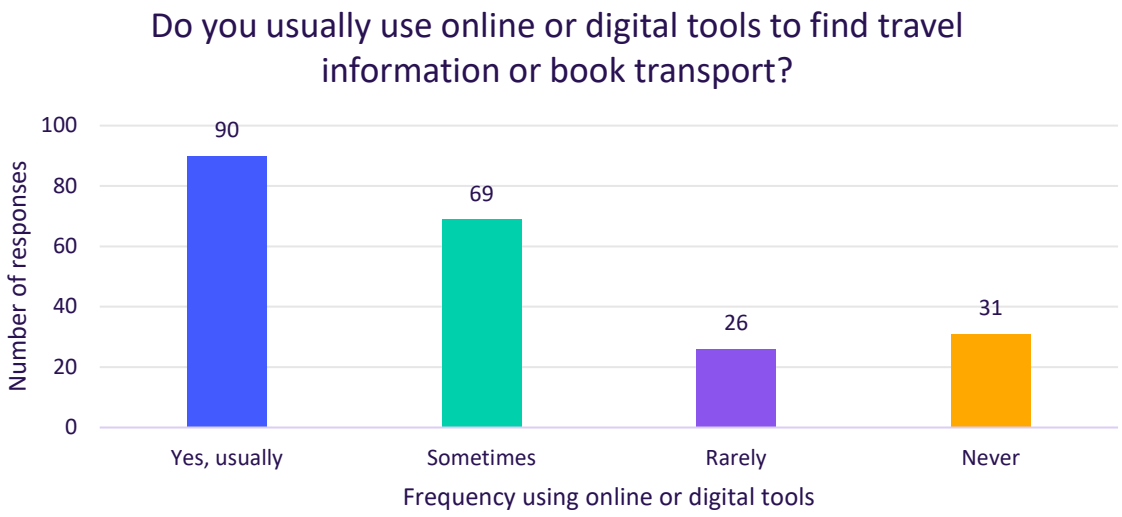


Figure 87: Frequency of using digital or online tools to find travel information or book transport

Severity of transport barriers

This question asked respondents to rate a series of transport barriers on a scale from 1-10 with 10 being the most severe barrier to Transport to Health. The highest rated barrier was 'a lack of reliable or available transport' demonstrating that for many a suitable, local, direct transport option is not available or convenient for all their healthcare journeys.

Rural isolation was the second highest rated option. This suggests that residents in the Scottish Borders can often feel isolated from major healthcare centres either at the BGH or at other acute centres in Edinburgh, Livingston or Glasgow.

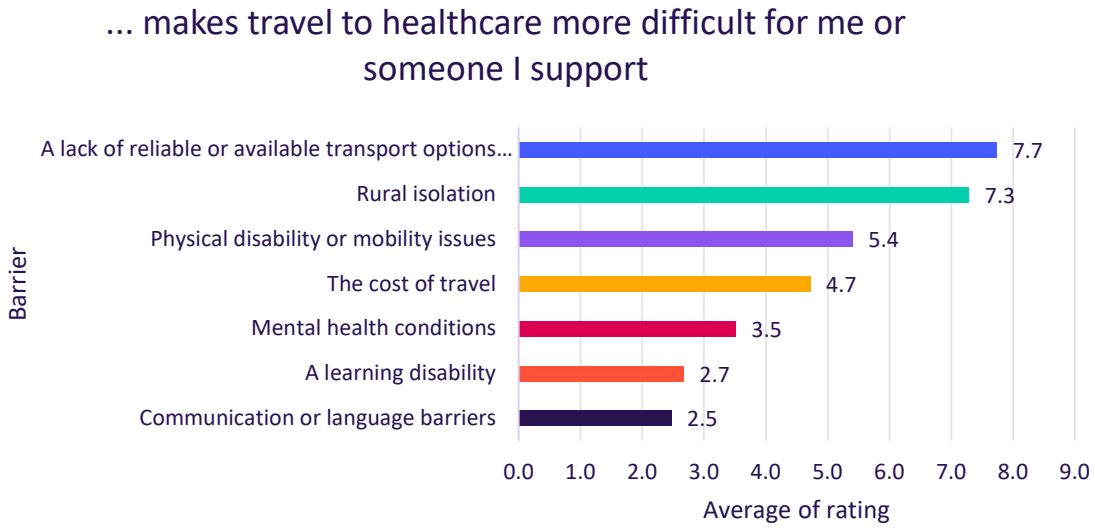


Figure 88: Average severity score given to barriers to travel to healthcare

Which group experience the greatest barriers

Figure 89 demonstrates that those who are disabled score 'physical disability or mobility issues' as a larger barrier than non-disabled respondents. In addition, there is also a disparity between disabled and non-disabled people when it comes to barriers like mental health and learning disability. Cost is

also a more significant barrier for disabled people, especially for those unable to use public transport and more reliant on taxis and community transport.

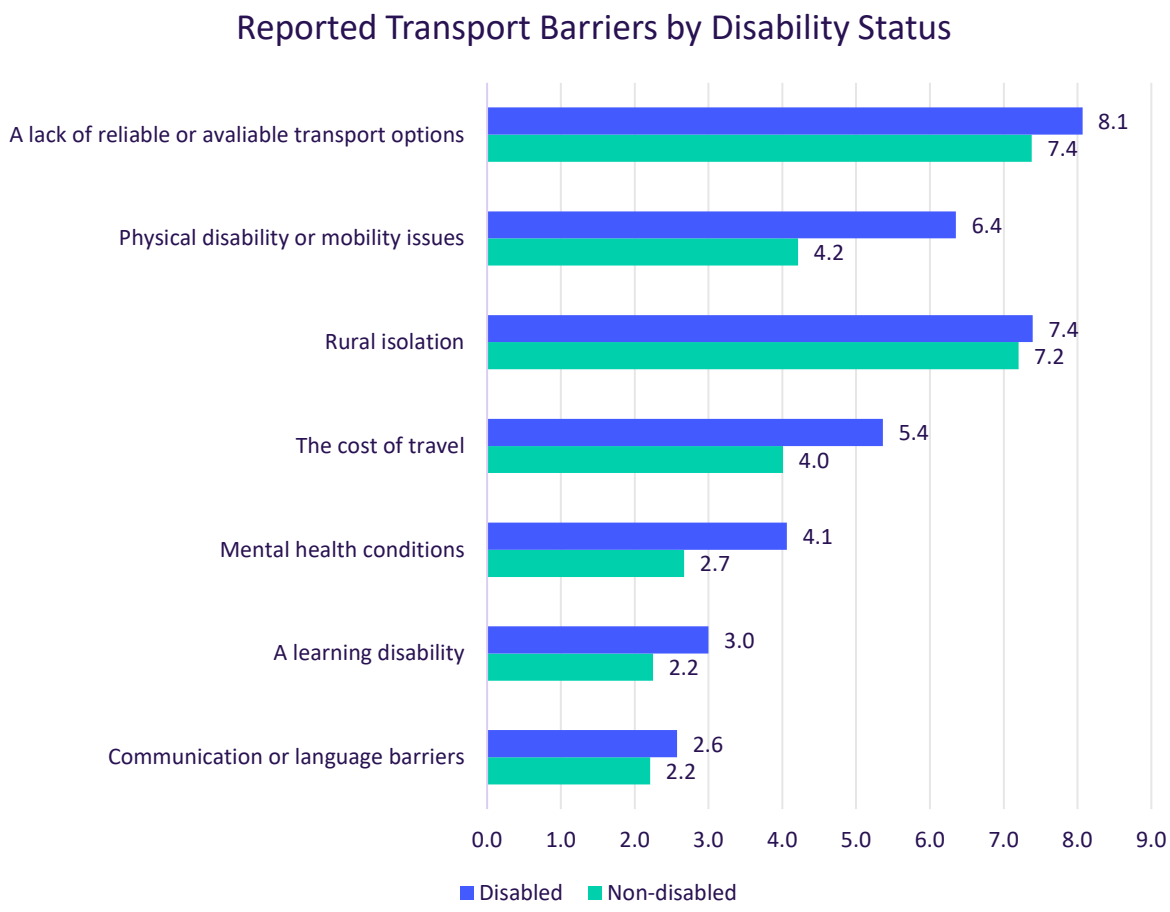


Figure 89: Average severity score of barriers to travel to healthcare by disability status

What improvements people want

By far the most popular option to improve access to healthcare was 'more direct public transport routes' at 79% of respondents. This reflects the factor that to access the BGH many people are required to change at Galashiels interchange which increases travel times. For those living in smaller villages in remote locations 2 changes can be required to reach the BGH. Additionally, to get to out of area healthcare appointments often requires at least one interchange. One respondent stated:

"There are no direct buses to the BGH from our locality, several stages are needed to get to the appointment. Out of area hospital appointments by public transport is a logistical nightmare for an 8am appointment".

40% of respondents chose 'better connections between different services'. This reflects a desire where interchanges are required for timetables to be coordinated between services, including services of different transport modes.

36% of respondents selected 'improved parking access'. Qualitative responses show that respondents find searching for a parking space stressful, especially when arriving for time-sensitive health appointments. A lack of parking at the BGH and hospitals in Edinburgh were of particular note.

24% selected 'better information and coordination across agencies' demonstrating a desire for a clearer, unified system of distributing transport information.

Fewer respondents selected 'reducing cost of travel' which may reflect a disproportionately high amount of bus pass holder and others paying low amounts for transport responding to this survey. It also demonstrates that, for healthcare journeys, the cost of transport is generally secondary to how convenient it is to travel.

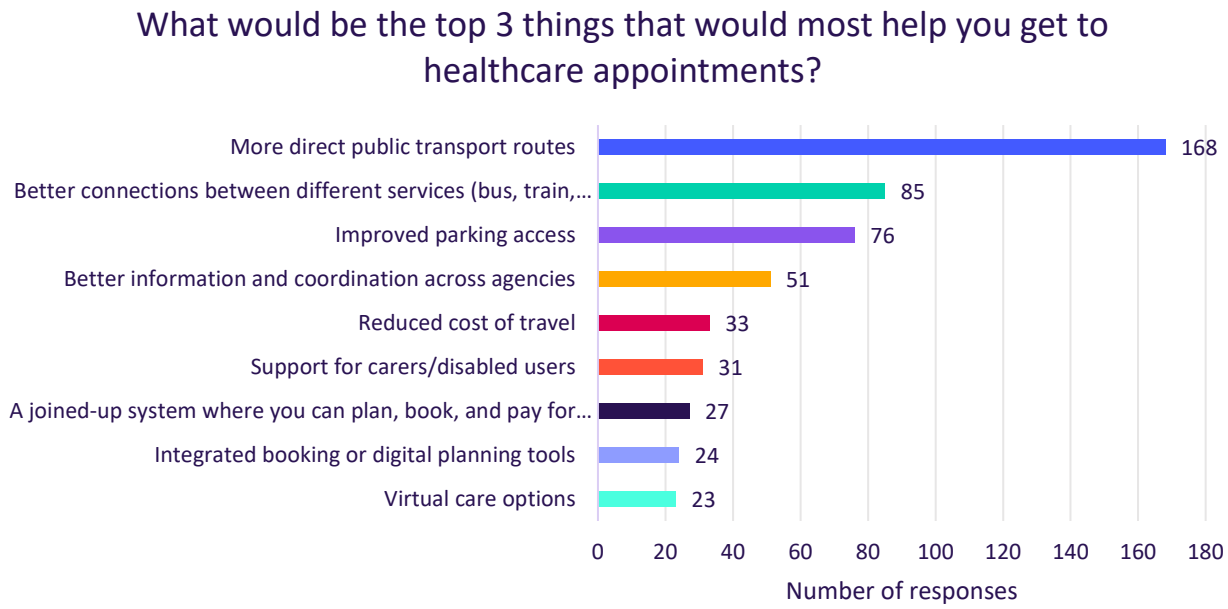


Figure 90: Most popular interventions to improve access to healthcare appointments

When it comes to interventions to improve access to travel information and ease of booking transport a plurality of respondents reported not requiring additional help. However, easier to use digital tools and paper timetables were both popular options to improve transport information for healthcare appointments.

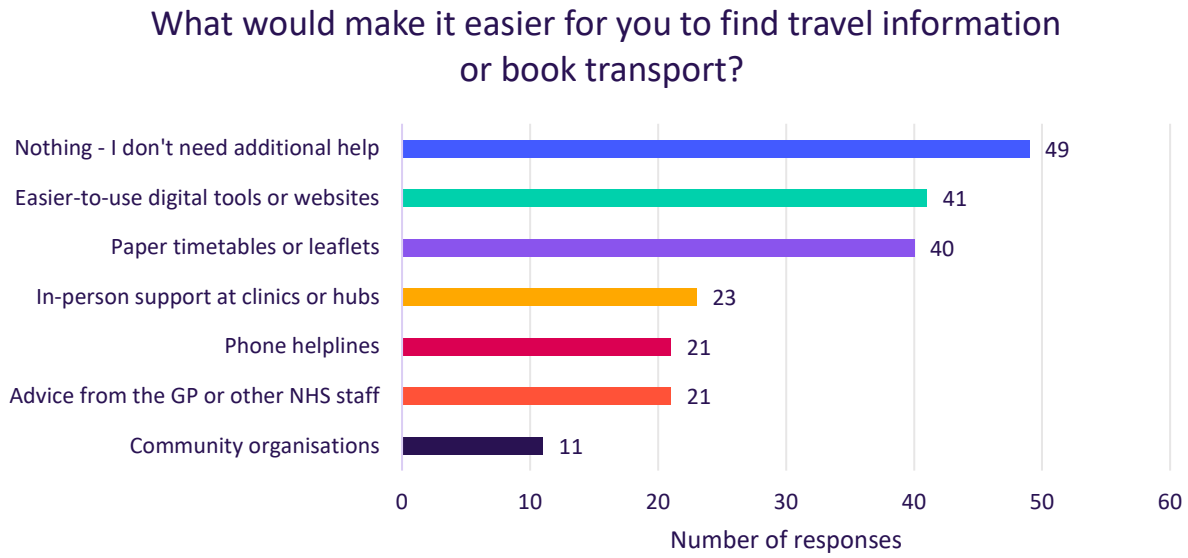


Figure 91: Most popular interventions to improve access to travel information and booking

Qualitative insights: Lived experience of travelling to healthcare

Primary and community care

Generally travelling to primary and community services were viewed more positively than secondary and tertiary care in the Scottish Borders.

> "GP, dentist no problem within walking distance. Optician just a local 20-minute bus ride away."

However there remains significant problems with access to primary and community healthcare.

GP surgery closures at Chirnside and Coldingham in the Eastern Borders have pushed primary care further away for some people. Coldingham has a higher than average than average proportion of over-65s at 29%[26].

> "Reduction in local GP surgeries (Chirnside) means longer trips and more difficult parking"

Despite it broadly being easier for people to get to primary services like dentists, pharmacies and GPs, those that have chronic health conditions or are elderly can still struggle to travel:

> "The GP is a 15-minute walk which I can't manage now between sight and disability, and I often have to reschedule vital appointments because I have no way of getting there."

For those unable to walk far, alternative services like community transport, taxi services or Demand Responsive Transport can often be missing, unreliable and expensive.

> "On my one occasion my partner was told to attend the GP immediately following test results indicating kidney failure. He was too ill to drive, and I was in Yorkshire for work. He was told to get a taxi - there were none."

Public transport can also be infrequent which can lead to difficulty getting to appointments:

> "GP appointment buses do not go close to Drs and run every hour so hard to schedule a same day urgent appointment and manage to get back. No time to visit pharmacy usually."

Secondary and tertiary care

[26] National Records of Scotland (2022), Population estimates for settlements and localities in Scotland: mid-2020

Distance to healthcare

Distance to healthcare is a major issue for residents in the Scottish Borders. 22% of 239 coded qualitive responses to questions 21 and 41 mention it as a difficulty in accessing healthcare.

Distance to the BGH is a common issue for residents as well frequently being referred to appointments in Edinburgh, Livingston and Glasgow.

When asked what locations particular difficulties in terms of Transport to Health have, 52% of respondents mentioned the BGH. Usually alongside issues related to in-direct and infrequent services and difficulty finding parking.

One respondent described the issue of long distances for healthcare both in the case of the BGH and out of area appointments:

> "Having to go to a hospital can be problematic, nearest hospital is over 20 miles away but sometimes you need to go to a city hospital which is much more challenging. The time taken to do this makes an appointment a whole day event. It also means additional costs."

Often key secondary and tertiary care services are located outside the Borders. For example, many Oncology appointments are located at the Western General Hospital in Edinburgh. This requires many public transport transfers to reach which can be challenging for a vulnerable group of patients.

> "Western General. Zero public transport from Borders (really expected to put an 80yr old cancer patient on a bus?)"

Many respondents in areas in the Eastern and Southern Borders, such as Eyemouth or Newcastleton expressed their wish to attend more specialist appointments in England (commonly Berwick or Carlile) rather than in the central belt of Scotland.

Public transport

56% of responses to questions 21 and 41 mentioned public transport service issues as a difficulty in accessing healthcare whilst 3% mentioned expense of public transport as a difficulty.

Indirect services:

The lack of direct services to the BGH was one aspect which respondents mentioned as well as long journey times to hospitals outside the Health Board area:

> "There are no direct buses to the BGH from our locality, several stages are needed to get to the appointment. Out of area hospital appointments by public transport is a logistical nightmare for an 8am appointment."

Respondents emphasised that having to take 2-3 buses each way to reach an appointment was time consuming, stressful and often didn't line up with appointment times.

Patients living West and South of the BGH often have to change at Galashiels, plus additional transfers for those in remote areas. Some in the Eastern Borders report having to catch buses south of the border into Berwick and change to reach the BGH for appointments at certain times.

Lack of public transport in local area:

Respondents often commented on there being no local bus in their area or a long walk to the local bus stop:

> "Our increasing age may eventually mean we cannot drive and there is no public transport from our home or near it. Nearest bus service is over three miles away"

Infrequent services:

Infrequent services was a major theme of responses. The negative impact of infrequent buses can be multiplied by poor connections between indirect services.

> "I cannot rely on public transport for any appointments as it is not frequent enough through my village. To get to the local hospital it takes over 2 hours on a bus and are so infrequent it would cause a lot of waiting around."

Parking at major hospitals

Parking was a major issue for respondents with 10% mentioning parking problems in answer to Q21 and 41. The BGH was the most cited location in answers related to parking, with respondents finding it stressful to find a spot, often worrying they could miss their appointment:

> "Parking at the Borders General Hospital is a nightmare I usually arrive an hour early to secure a parking place"

As the quote above indicates patients often arrive early to their appointment to secure parking.

Community transport

Community Transport can be unreliable, unavailable or expensive in the Scottish Borders.

One wheelchair user stated:

> "Community transport is not always available. Taxi is too expensive."

As well as being unavailable, community transport is often expensive. As mentioned by several respondents:

> "Community transport support is very expensive and not fully reliable due to volunteer shortages."

One GP who responded to the survey said they didn't know what to recommend to patients to get to hospital appointments they were referring. They mentioned community taxi services:

> "Community taxi services can cost more than 60 pounds for a single hospital trip and do not seem to be reimbursable. I've had patients decline treatment due to lack of transport."

The available community transport options and their prices in the Scottish Borders are listed in Table 1.

Table 2: Community Transport Services: Scottish Borders

Service	Description	Price	Relevant survey quotes
Borders Wheels	"The Borders Wheels Community Transport Service operates a number of wheelchair accessible vehicles, supported by volunteer drivers. Our service is available for individuals living independently or in care who need help with transport, and also for community/voluntary groups."	Individual journeys: 50p/mile Minimum charge of £10 and a flat rate surcharge of £5 per journey.[27]	"I have tried the likes of Teviot Wheels but have found them hit and miss"
Cancer Cars Scotland	Transport support for cancer patients in the Scottish Borders based at Border Macmillan Centre	55p/mile for non-cancer patients For cancer patients a minimum donation is suggested- e.g. £25 Borders to Edinburgh return[28]	
Royal Voluntary Service	Community transport for health appointments and social isolation	£8 minimum charge	"I have never been able to access voluntary drivers always unavailable and needs one week notice"

Patient transport

Patient transport was mentioned it was usually in relation to difficulty getting an appointments or other problems with the service. This reflects the changed Patient Needs Assessment and stretched resources of the Scottish Ambulance Service. One respondent described being refused patient transport:

[27] Borders Wheels, Community Transport
[28] Cancer Cars Scotland, Cancer Support Cars

"I have breathing problems and difficulty getting about I have several times tried to get patient transport and have been refused"

This lack of capacity from the SAS leads more acutely ill patients struggling to find ways to reach appointments. It often means relying more on lifts from friends and family, using expensive taxis or community transport.

Accessibility

Many respondents mentioned accessibility issues in their answers. Accessibility covers a range of needs and circumstances. Some of the issues raised by respondents with disabilities, long term health conditions or mobility issues include:

- Public transport to be more accessible for wheelchair users
- Being unable to drive due to disability or condition
- Lack available community transport as an accessible alternative to public transport
- Inflexibility of patient transport services (fixed pick-up times)
- Lack of available taxi services and wheelchair accessible taxis, appointments have to be booked in advance
- Disabled parking difficult to find at BGH and parking being too far from the entrance
- A long walk/wheel to nearest public transport which is difficult for those with mobility issues
- Being reliant on lifts for transport

"No public transport, I don't drive and am a wheelchair user, so transport is a major issue, especially for early morning appointments when taxis are on the school run and I need blood tests at specific times."

Additional impacts

This section describes some of the impacts on those travelling to healthcare, caused by the problems described in the previous sections.

Forced or encouraged to drive / Reliant on lifts

A common impact of long distances to healthcare appointments and indirect public is being reliant on a car or on lifts from other people. 21% of qualitive responses mentioned being reliant on their car or lifts from others to access healthcare often due to public transport issues, disability and mobility issues, or the long distances required to reach healthcare.

"Wouldn't be able to attend without a car, public transport does not fit around hospital appointments"

A recurring theme of people who feel driving is their only options to attend healthcare appointments, is a strong concern about how they will cope when they are too elderly to drive. This reflects the older demographics of people who responded to our survey. It also highlights that an aging population will find it increasingly harder to reach healthcare, especially in the rural areas found in the Borders.

Time off work or wasted time

6% mentioned that poor Transport to Health had wasted their time or caused them to have to take additional time off work to attend appointments.

"a full day off work to visit the hospital for a short appointment costs money or holiday time"

Forced to use expensive / unavailable taxis

9% mentioned they were forced to use expensive taxis for healthcare appointments. Additionally, many respondents mentioned that taxis were often unavailable.

"I have to get a taxi when I am not well enough to walk to the bus it is very expensive"

Often those who are reliant on taxis have other underlying health conditions or are wheelchair users.

Worsens condition / acute impact on vulnerable group

Long journeys by public transport can often be unformattable or painful for elderly people, people with long term health conditions, and those returning from receiving major treatment.

"Bus would make journey very long and take the whole day and my person suffers with chronic fatigue"

Missed or delayed appointments

Missing, delaying or cancelling an appointment was one of the impacts of poor Transport to Health. Common reasons for not travelling to appointments or delaying appointments include appointment times not lining up with bus schedules, no public transport options the area, or long and in-direct public transport options making travelling unfeasible.

"No public transport I don't drive so rely on the local taxi service which is costly and sometimes I'm unable to afford to attend."

Summary of insights for NHS Borders

The challenges which face NHS Borders are similar in nature to many Health boards but exacerbated by a challenging rural geography and older population. Access to secondary care facilities was the biggest priority from those who responded to our survey. Problems included having to attend healthcare appointments multiple hours away from their home, indirect public transport options to

Borders General Hospital, stretched parking facilities, and accessibility issues making reaching transport options difficult.

↘ Increasing distance to primary care

For those who have recently lost a GP in their village or who live in small villages and rural areas access to primary healthcare can be challenging. This is especially the case for those who don't drive or have mobility issues. Even when the local GP, dentist or Pharmacy is in walking distance this can be an issue for disabled people, those with mobility issues, and elderly people.

↘ Distance to healthcare

Distance to secondary and tertiary healthcare services was a massive barrier for many in the Scottish Borders. In the first instance, the BGH covering the whole of the Scottish Borders from West Linton to Newcastleton to Eyemouth means there is a challenge in making the site accessible by driving as well public and community transport over distances stretching up to 40 miles.

The second aspect of this theme is the distance to out of area appointments, often in the central belt (Edinburgh, Livingston or Glasgow). This can turn travelling for healthcare into a time consuming and expensive process, even for those who have access to a car or someone who can give them a lift. For those reliant on public, community or patient transport, the issue of distance to healthcare sites is exacerbated.

↘ Public transport service issues

The most cited issue amongst qualitive responses were issues related to public transport service.

Indirect services force patients to take multi-stage journeys with long transfer times. This is seen as time-wasting, and an extra burden for those suffering with health conditions and mobility issues. In-direct services were also often blamed for struggling to attend appointments at certain times of day such as the morning.

Lack of public transport in the local area was repeated across responses. Respondents often stated that there was 'no public transport'. This demonstrates that for those in smaller rural settlements, public transport is not an option. Another issue was the distance required to reach public transport, with those with mobility issues struggling to walk or wheel to the nearest bus stop, with some using a taxi to get to their nearest bus stop.

Infrequent bus services were cited as problem for getting to appointments on time. Bus services often only run once per hour or a few times per day, meaning some appointment windows at hospitals and local primary healthcare sites become unreachable.

↘ Parking at major hospitals

Respondents often reported having to arrive early for appointments to get a parking space at the BGH. This means additional time and stress for many worried about missing appointments

↘ Community transport

Community transport was seen as limited due to the driver volunteer shortage, meaning there was difficulty booking appointments and reliability issues. The cost of community transport was also seen as a drawback for those who use it.

↘ Patient transport

The primary issue with non-emergency ambulance is a lack of capacity from the SAS, which means patients are often refused travel. This makes them reliant on lifts from others or using other modes which are unsuitable for their condition.

↘ Accessibility

Accessibility issues covered a wide range of problems. These often stem from being unable to drive to appointments. These include the accessibility of public transport, a lack of accessible taxis available, difficulty travelling to the nearest bus stop. Disability, mobility issues and old age often exacerbated the problems outlined above, having a more acute impact.

NHS Forth Valley – evidence summary

Area overview

NHS Forth Valley covers the local authority areas of Falkirk, Clackmannanshire and Stirling, serving a population of around 300,000 people. However, this Health Board area does not align with our study area as Stirling lies outwith the SEStran partnership area. Within the SEStran region, the analysis in this report focuses on Falkirk and Clackmannanshire. The area includes a mix of settlement types and healthcare facilities, including:

- Urban centres such as Falkirk, Grangemouth and Larbert
- Growing commuter and suburban towns such as Polmont, Bo'ness, Denny and Bonnybridge
- Rural and semi-rural communities across Clackmannanshire (including the Hillfoots towns of Dollar, Tillicoultry, Alva and Menstrie)
- Primary hospitals and specialist centres: Forth Valley Royal Hospital (Larbert) as the main acute hospital, supported by Stirling Health Centre and Falkirk Community Hospital for local and outpatient services

These contrasting geographies shape the transport needs of the population. Urban areas generally benefit from stronger public transport coverage, while many rural and semi-rural settlements face longer or indirect journeys to reach FVRH or other hospital-based services.

Figure 92 illustrates this geography, showing the distribution of settlements, key A-roads and motorways (including the M9 and M80), and rail corridors such as the Edinburgh–Glasgow line and the Croy–Larbert corridor. Transport accessibility is strongest along these strategic corridors, whereas parts of Clackmannanshire and rural Falkirk experience weaker public transport provision.

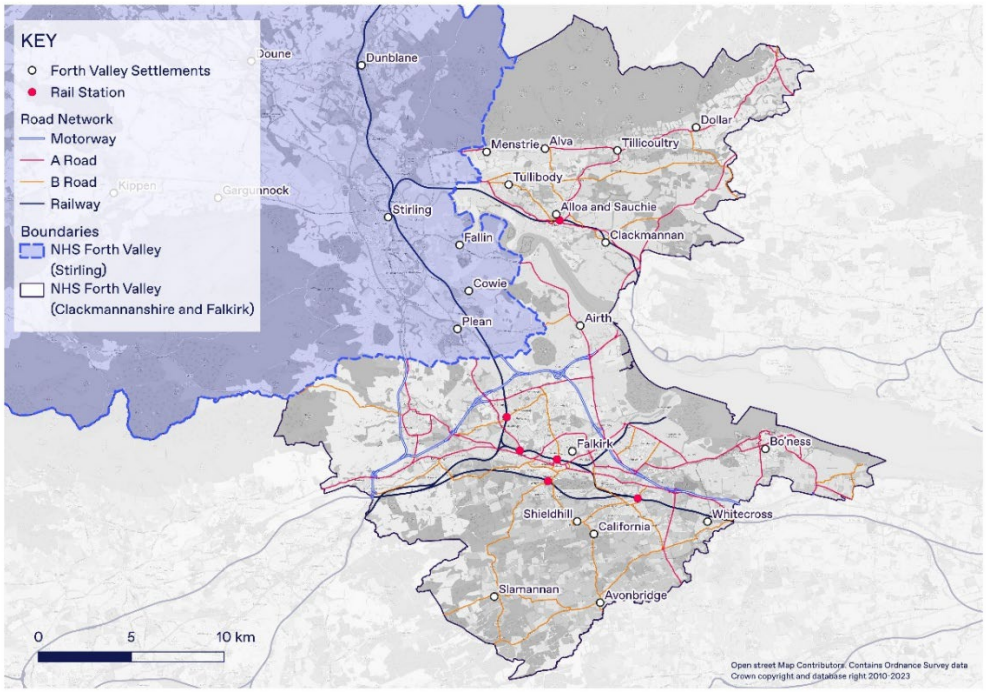


Figure 92: NHS Forth Valley settlements

Primary care facilities are generally aligned with local population centres; however, Figure 93 shows that secondary and acute healthcare services are highly centralised. Forth Valley Royal Hospital acts as the single regional acute hospital, meaning that significant cross-boundary and cross-settlement travel occurs from Falkirk, Clackmannanshire, Bo'ness, the Hillfoots towns and other communities. This centralisation results in longer travel times for many residents, particularly those without access to a private car.

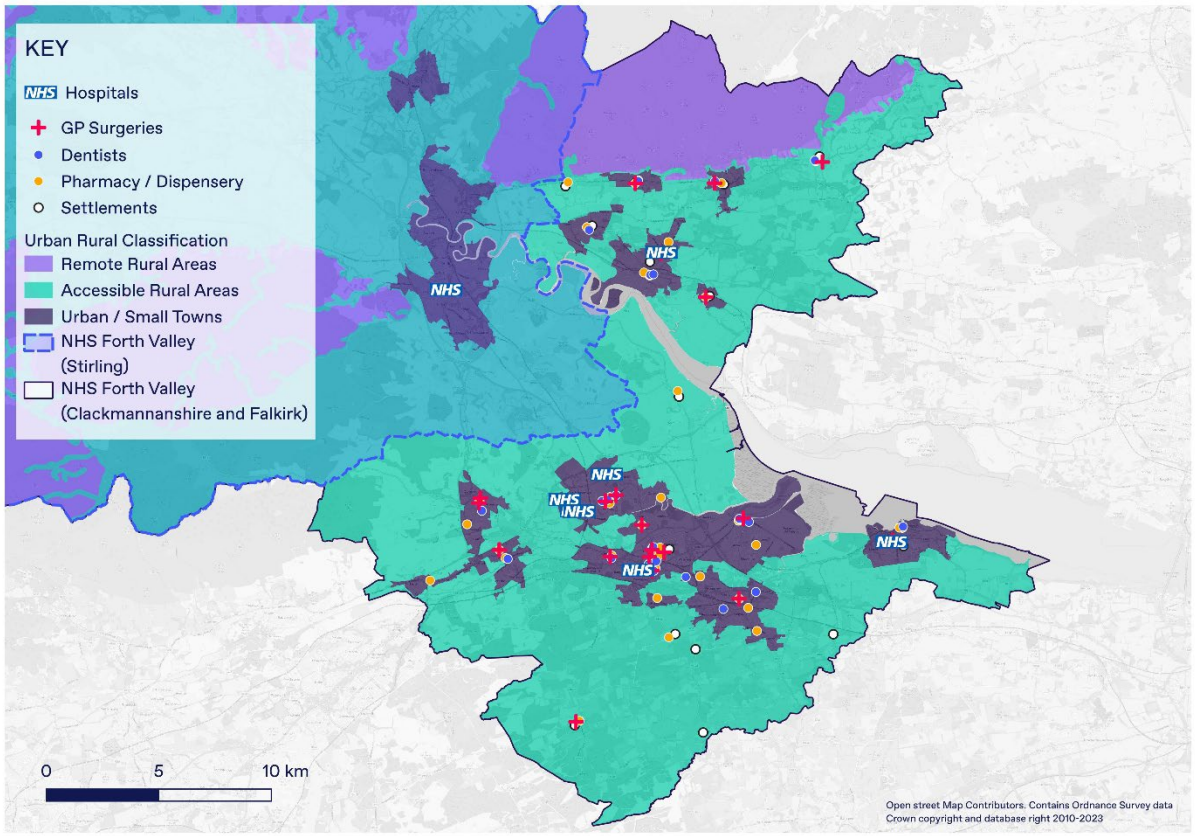


Figure 93: NHS Facilities Forth Valley

Figure 94 presents modelled public transport travel times from Transport Scotland's TRACC model. This model was chosen for this area due to patients often travelling to the two primary hospitals in the area FVRH and Stirling Community hospital. Most areas in Clackmannanshire have journey times exceeding 40 minutes to FVRH or Stirling Community hospital with a few areas exceeding 60 minutes. Some areas in the East Falkirk like Bo'ness also experience longer journey times of some exceeding 1 hour.

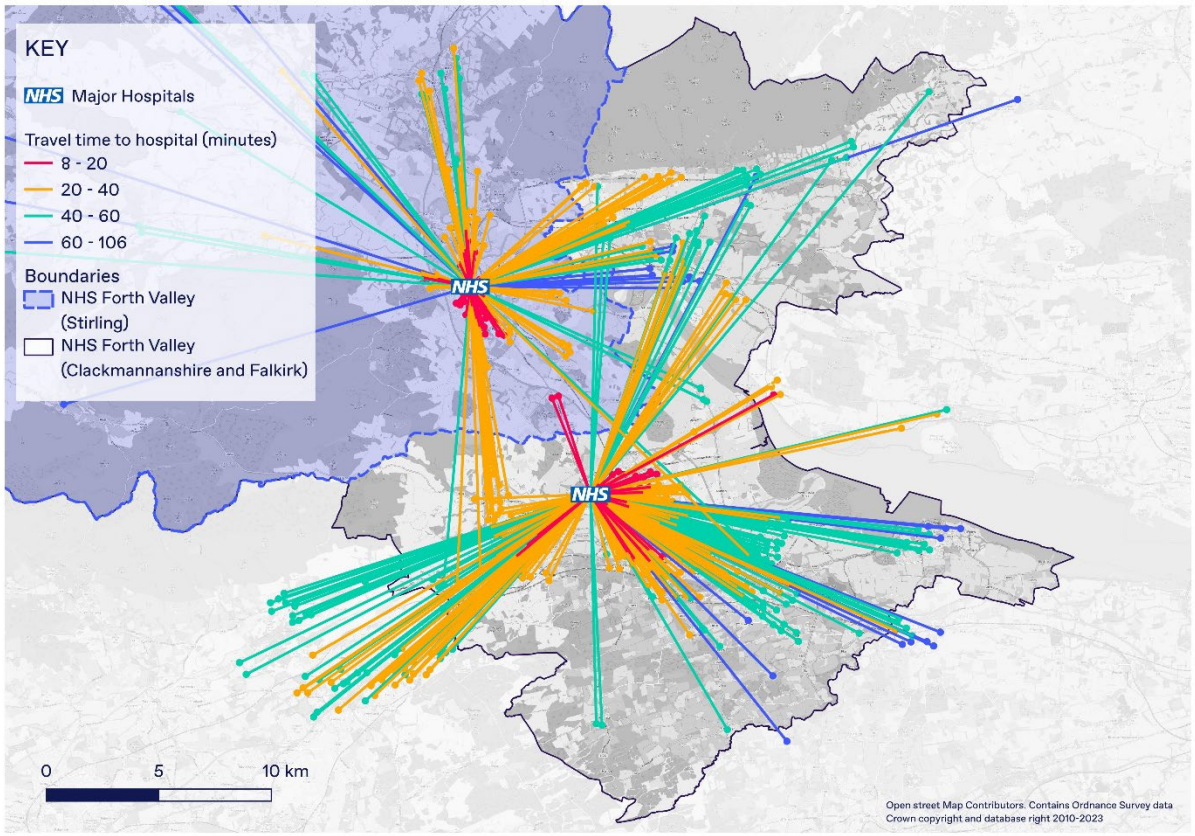


Figure 94: Public transport travel times and number of interchanges to FVRH

Figure 95 shows the proportion of the population which lives in each of the 5 SIMD quintiles. The index of deprivation quintiles represent 5 equal segments of the Scottish population from 1 (most deprived) to 5 (least deprived). Among the two local authorities in both NHS Forth Valley and our study area Falkirk has a lower proportion of the population in the most deprived 20% than the Scottish average. Clackmannanshire on the other hand has more of its population in datazones which are in the 20% most deprived. This is in addition to longer journey times to hospitals at FRVH and Stirling community hospital; these areas should be a priority focus for intervention.

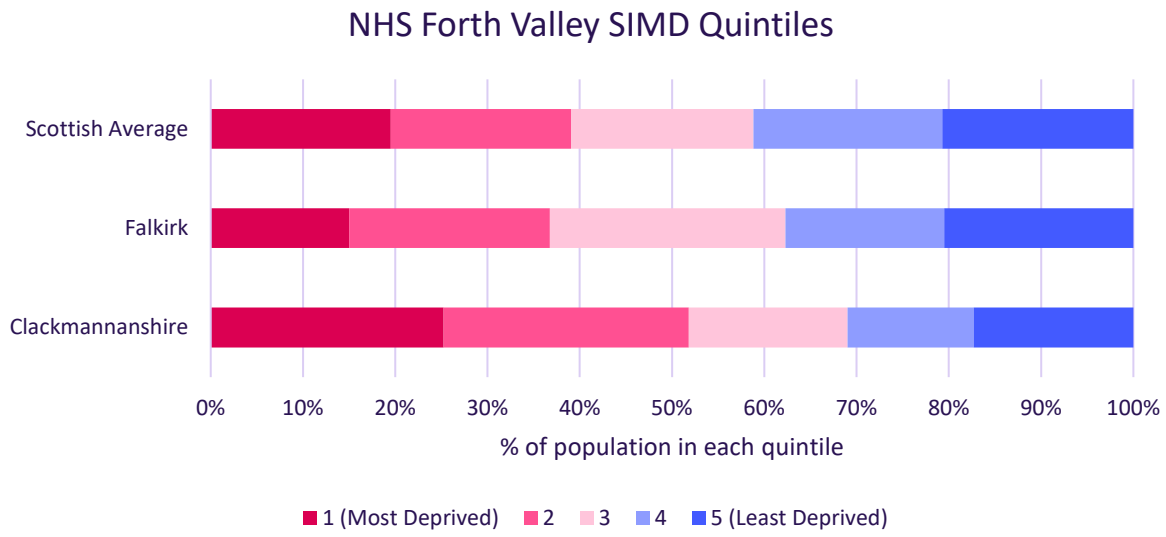


Figure 95: NHS Forth Valley proportion of population in each SIMD quintile

A total of 196 survey respondents survey respondents live within the NHS Forth Valley area, providing detailed insight into the transport challenges and behaviours of residents in Falkirk and Clackmannanshire when accessing healthcare services.

Survey respondent characteristics

Survey respondents from the Forth Valley are less likely than the general population to have access to at least one car or van. This could show a greater interest in the survey from those who struggle to reach healthcare without having access to private transport.

An even greater majority of respondents from the Forth Valley area were women at 79%. 67% were over 60 years old which is in line with the overall survey average.

Similar to other Health Board areas, Forth Valley respondents were more likely to have a long-term health condition or disability and were more likely to provide unpaid care to others.

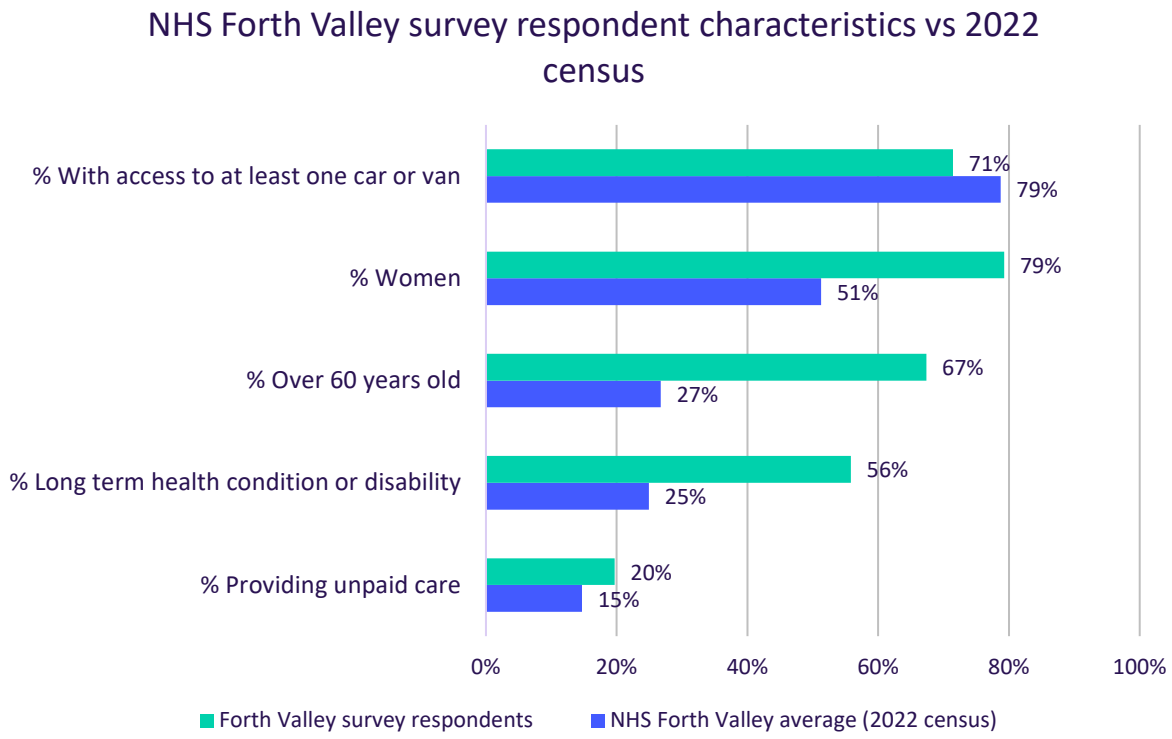


Figure 96: NHS Forth Valley characteristics – respondents vs census

Patterns of healthcare use

Most respondents in NHS Forth Valley reported travelling for healthcare relatively infrequently. The majority of journeys across most appointment types were reported as either once a year or less, or every few months. As expected, GP and local clinic appointments were attended more regularly than hospital-based services, reflecting their role in routine and ongoing care.

Outpatient secondary care appointments are a common healthcare journey type in the area with most respondents reporting attending one at least every few months. This journey type varies in length as many outpatient appointment types can be held at more local community facilities like Stirling Community Hospital and Clackmannanshire Community Healthcare Centre. This reduces the

need to travel long distances, especially for those living in Clackmannanshire. However, the precise split between appointments at community facilities and the FVRH is not known.

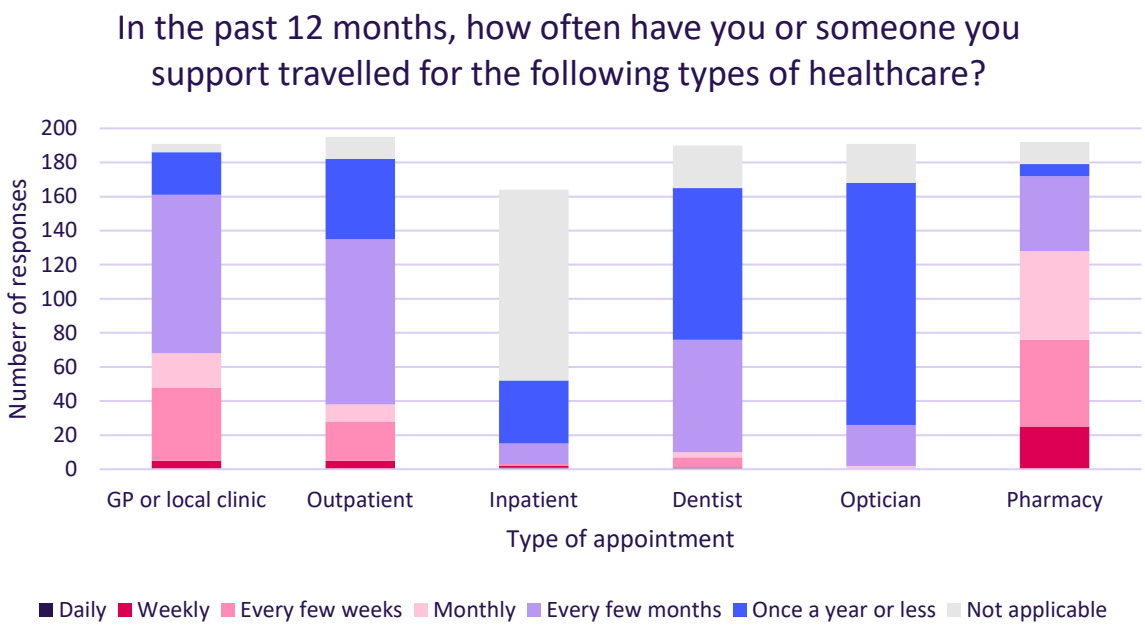


Figure 97: Frequency of visits

Pharmacy visits showed higher frequency than other services, with a notable proportion of respondents attending monthly or every few weeks. Inpatient appointments were least frequent overall, and most commonly reported as not applicable or occurring once a year or less.

How long journeys take

Journey times vary considerably depending on the type of healthcare being accessed. Travel to GP surgeries, pharmacies and local clinics was most commonly reported as taking under 15 minutes, reflecting their closer alignment with local settlement patterns.

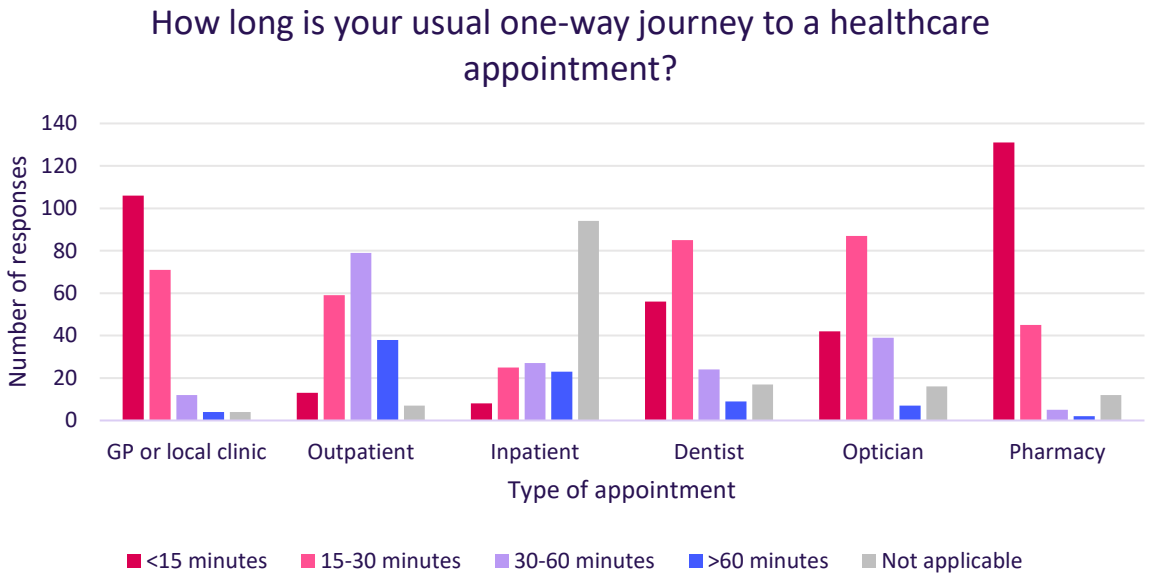


Figure 98: Journey time

In contrast, journeys to hospital-based services, particularly Forth Valley Royal Hospital, were more likely to exceed 30 minutes. A significant proportion of respondents reported travel times of over 60 minutes for inpatient and specialist appointments, especially those travelling from Clackmannanshire or the outer parts of Falkirk. These longer journeys often involved indirect routes or multiple stages.

How people travel to healthcare

Private car use dominates healthcare travel across NHS Forth Valley, either as a driver or passenger.

Bus travel is the most commonly used public transport mode, particularly for local services and for respondents living in urban areas. Walking plays a role mainly for short trips to GP surgeries or pharmacies.

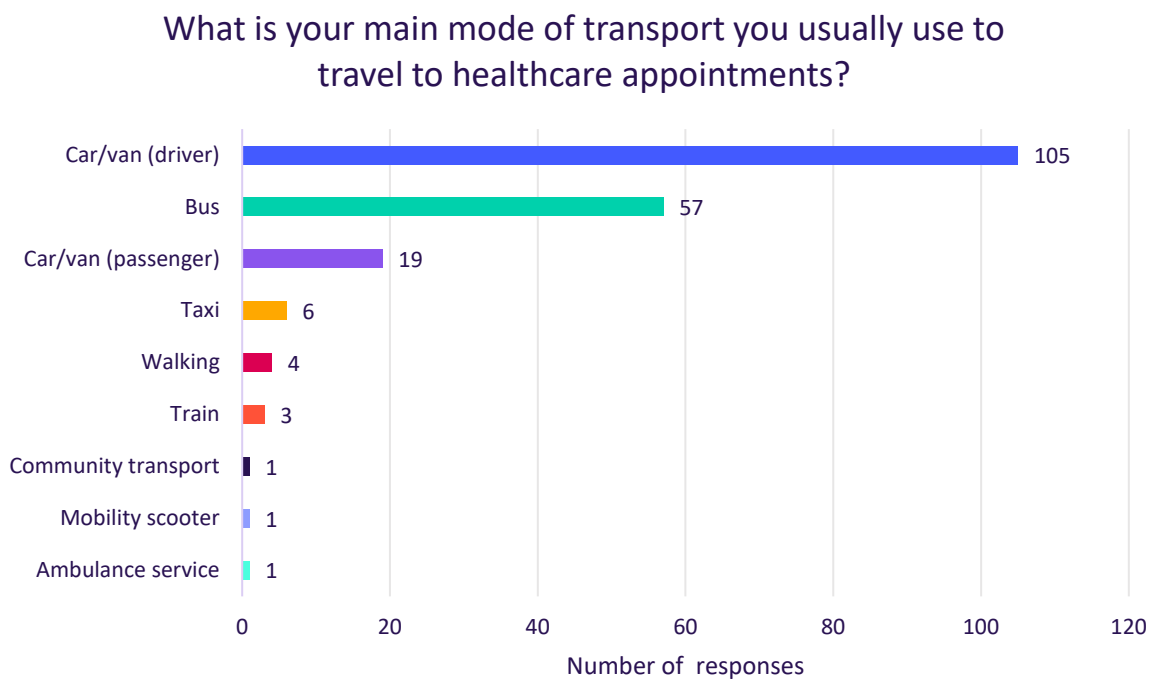


Figure 99: Main mode of transport

When considering backup options, many respondents indicated they would rely on lifts from family or friends if their main mode was unavailable. Public transport and taxis were also cited as alternatives, although a small but important group reported having no suitable backup option, increasing the risk of missed appointments if their usual transport fails.

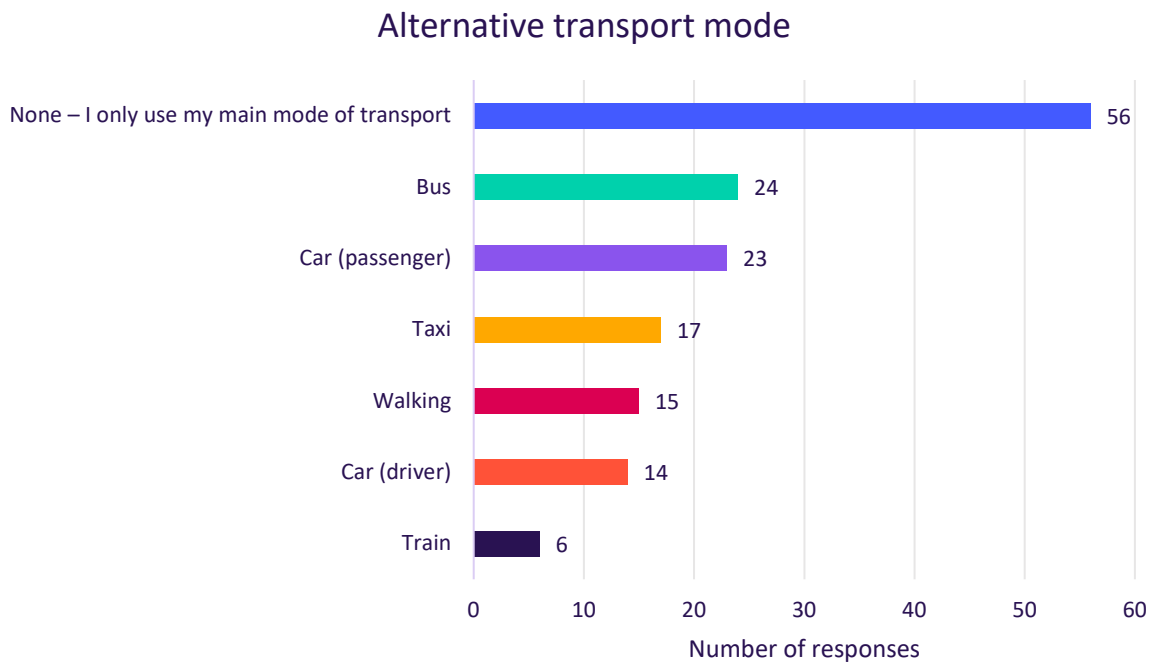


Figure 100: Alternative transport mode

Reliability of available transport

In line with other health board areas, most respondents described their usual transport to healthcare as reliable. However, a notable minority reported that transport is only sometimes reliable or frequently unreliable. Issues such as delayed or cancelled bus services, missed connections and congestion around hospital sites were highlighted as sources of uncertainty, particularly for time-sensitive appointments.

When considering reliability by mode car drivers found their mode the most reliable whilst, car passengers mainly selected 'usually reliable' and bus users were most likely to select 'sometimes reliable'.

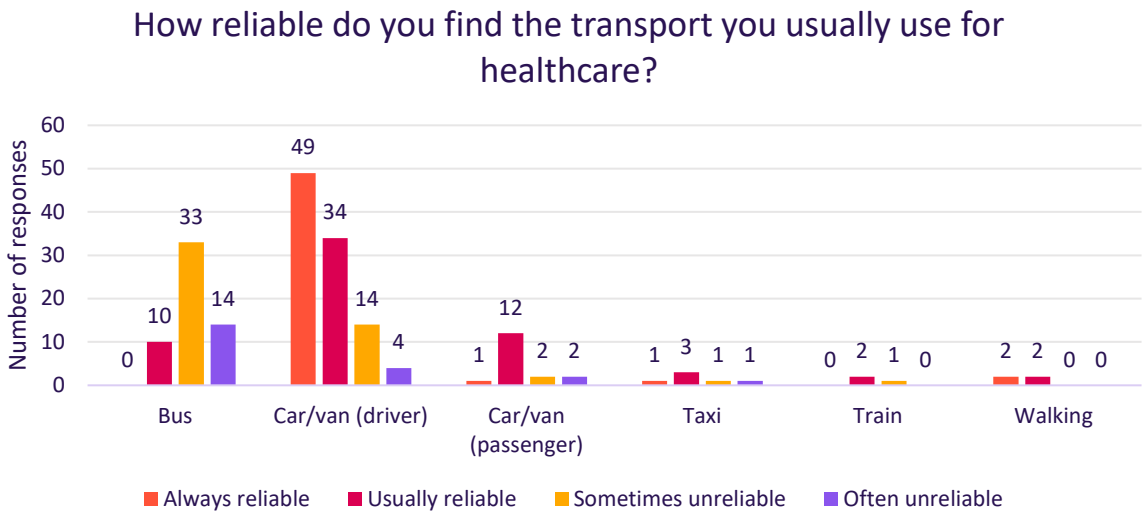


Figure 101: Transport reliability

Missed or delayed appointments due to transport

Around one third of respondents reported having missed or delayed a healthcare appointment because of transport-related issues.

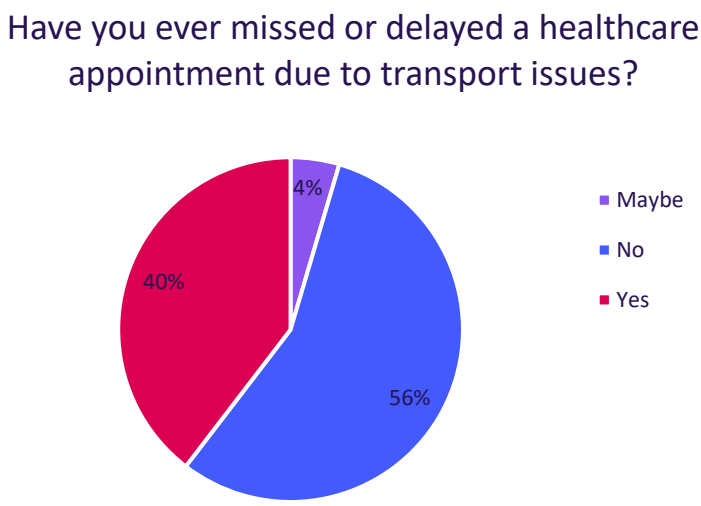


Figure 102: Missed appointments

The most commonly cited reasons were delays to public transport services, traffic congestion and difficulties with parking. Accessibility and mobility-related barriers also featured strongly, particularly for respondents with long-term health conditions or caring responsibilities. In some cases, reliance on others for transport or the lack of suitable alternatives contributed to missed or postponed care.

Figure 103: Reason for missed appointment

Effect of transport costs on attendance

Most respondents stated that transport costs do not affect their ability to attend healthcare appointments. However, a minority reported that costs either sometimes or regularly influence attendance, indicating that affordability remains a barrier for some groups, particularly those requiring frequent or long-distance travel.

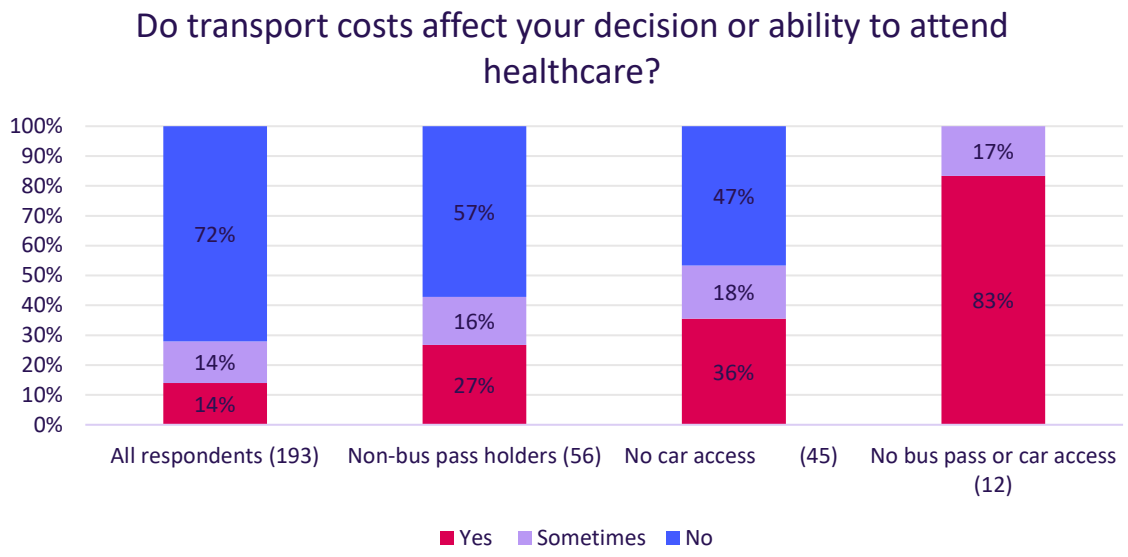


Figure 104: Cost of journey affects attendance

When considering those that face more up-front costs non-bus pass holders were more likely to report transport costs as a barrier and those without access to a car were even likelier to find transport costs a barrier.

Cost of the most recent healthcare journey

The majority of respondents reported that their most recent healthcare journey involved no direct cost. Among those who did incur costs, most spent under £10, with only a small number reporting higher expenses. This suggests that while many journeys are low-cost, a minority of patients face significant travel expenses.

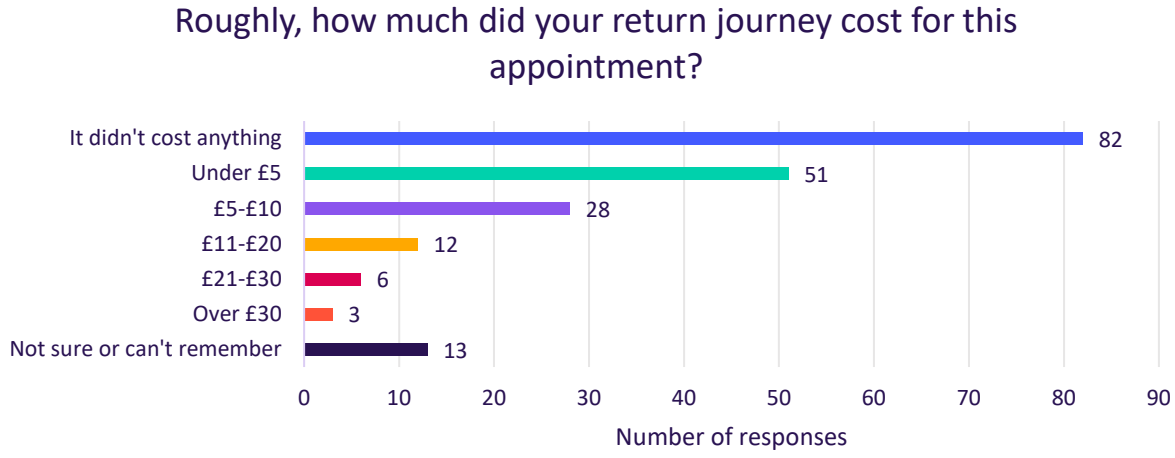


Figure 105: Cost of journey

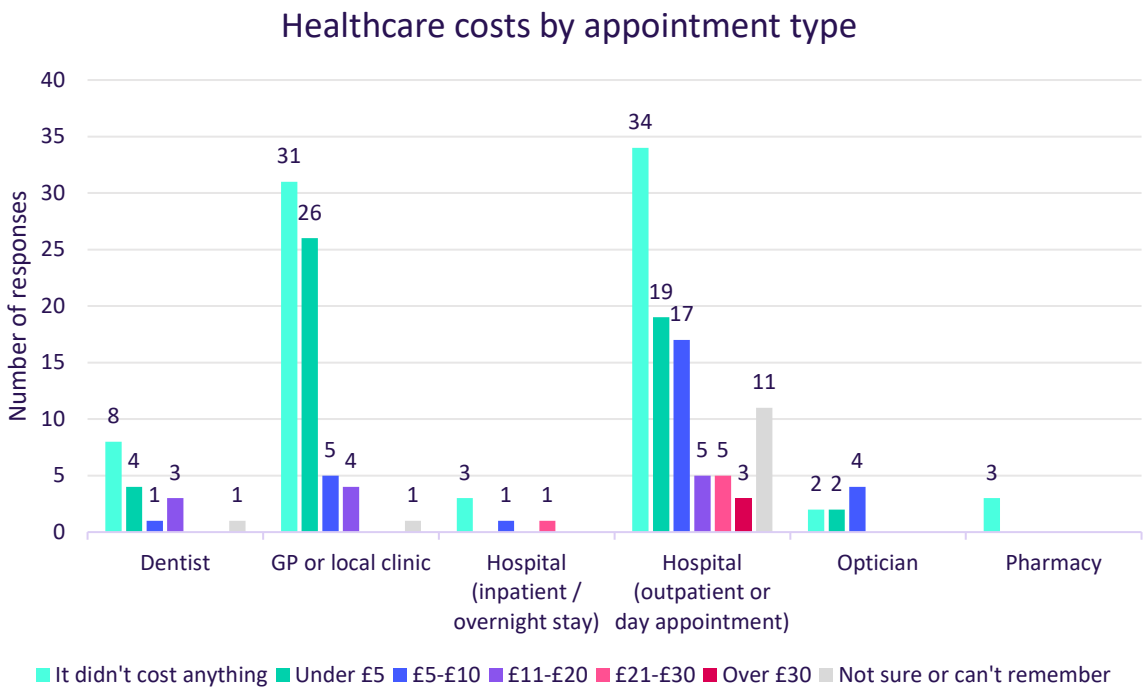


Figure 106: Cost of healthcare per appointment type

Healthcare travel costs vary by appointment type. GP, pharmacy and local clinic visits are most likely to incur no cost, reflecting their proximity to where people live and the ability to walk or use short bus journeys. In contrast, hospital-based appointments, particularly outpatient and inpatient care, are more likely to involve a financial cost. Where costs are incurred, they are most commonly associated with longer journeys, use of private cars, or reliance on taxis where public transport options are limited or unsuitable. This indicates that travel costs are more closely linked to the location and type of service than to healthcare use overall.

How people find travel information

Respondents most commonly used digital tools such as online maps and journey planners to find travel information. NHS websites and appointment letters were also important sources. Fewer respondents relied on advice from healthcare staff, community transport providers or local transport apps.

Ease of accessing and understanding information varied. While many reported that information is usually easy to find, a notable minority had trouble particularly where journeys were complex or required coordination across different services.

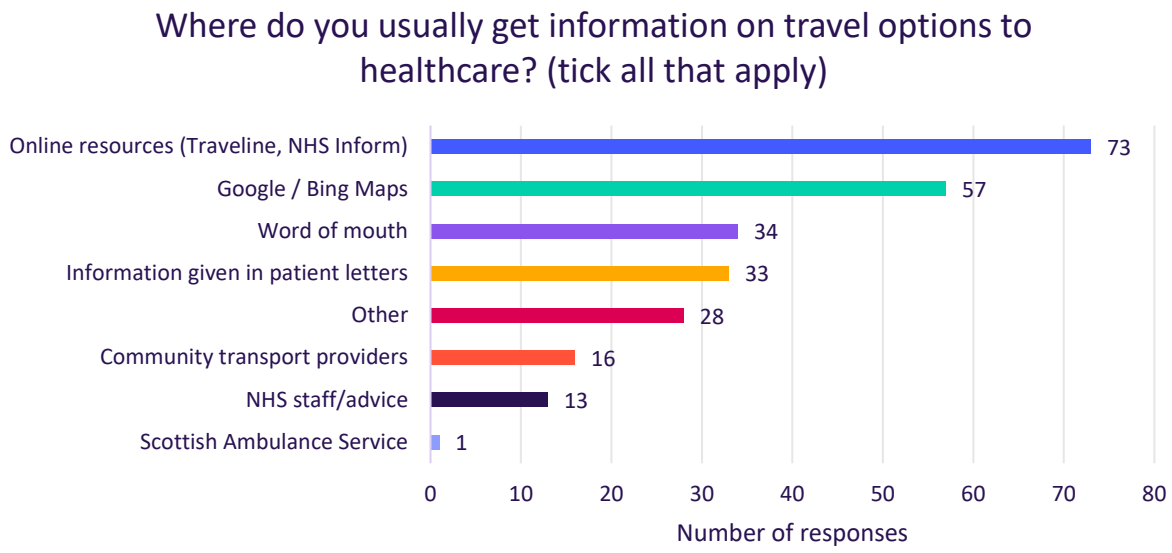


Figure 107: Where do you get your information?

Digital confidence in planning healthcare travel

Overall digital confidence among respondents was high, with most reporting that they are confident using online tools to plan or book travel. However, a smaller group reported limited confidence or reliance on non-digital methods, highlighting the continued need for accessible offline options.

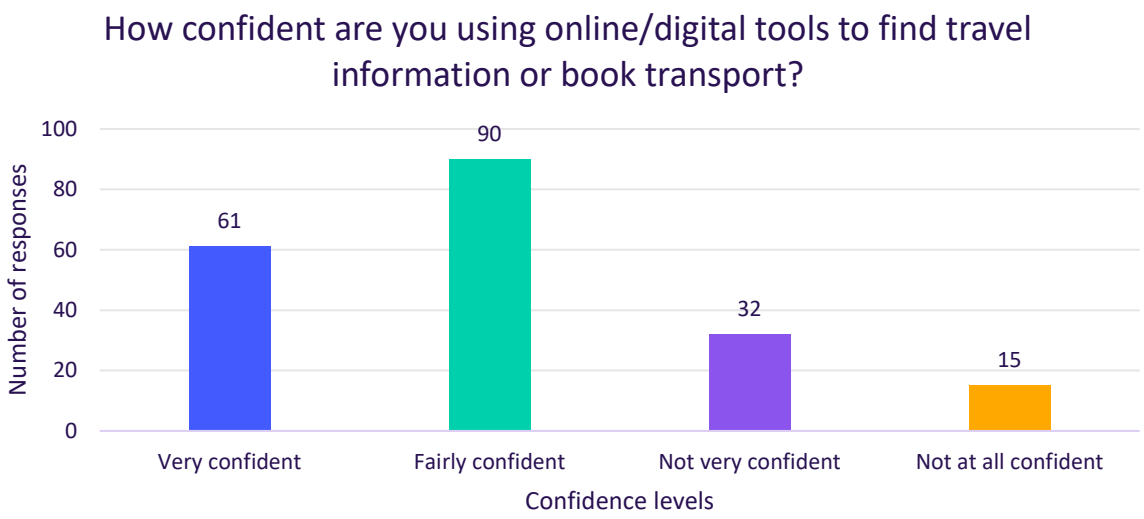


Figure 108: Confidence online

Most respondents reported that they usually use online or digital tools to find travel information or book transport for healthcare appointments. A further proportion said they use digital tools sometimes, while a smaller group reported that they rarely or never do so. This suggests that digital tools are the primary method for planning healthcare travel for most people in NHS Forth Valley, but that reliance on non-digital options remains important for a minority, particularly where confidence, accessibility or complex journeys present barriers.

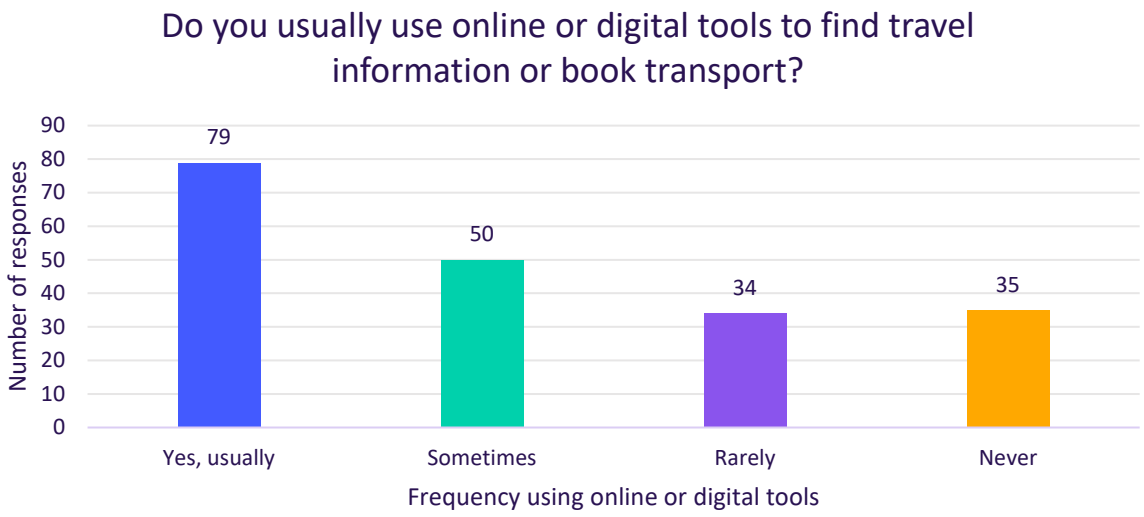


Figure 109: Do you utilise online tools

Severity of transport barriers

The most significant barriers reported relate to the lack of direct public transport routes, limited-service frequency and parking difficulties at hospital sites. Poor coordination between services and challenges linked to accessibility and mobility were also highlighted. Cost was identified as a barrier for fewer respondents, but where present, its impact was substantial.

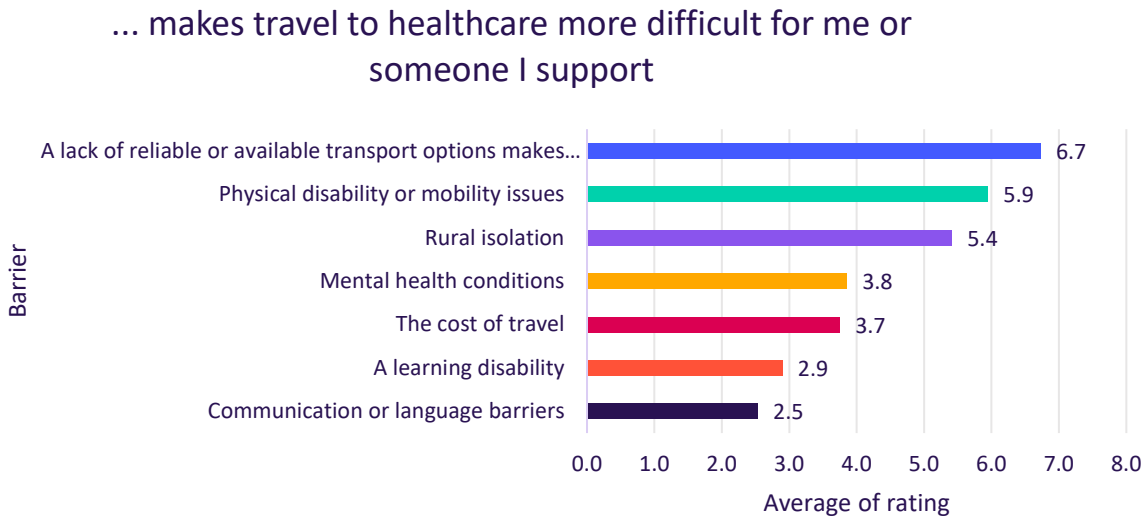


Figure 110: Difficulties with travel

Which group experience the greatest barriers

People with disabilities, long-term health conditions and caring responsibilities were more likely to experience transport-related barriers. Older people and those without access to a private car reported particular difficulty with indirect journeys, digital tools and service reliability.

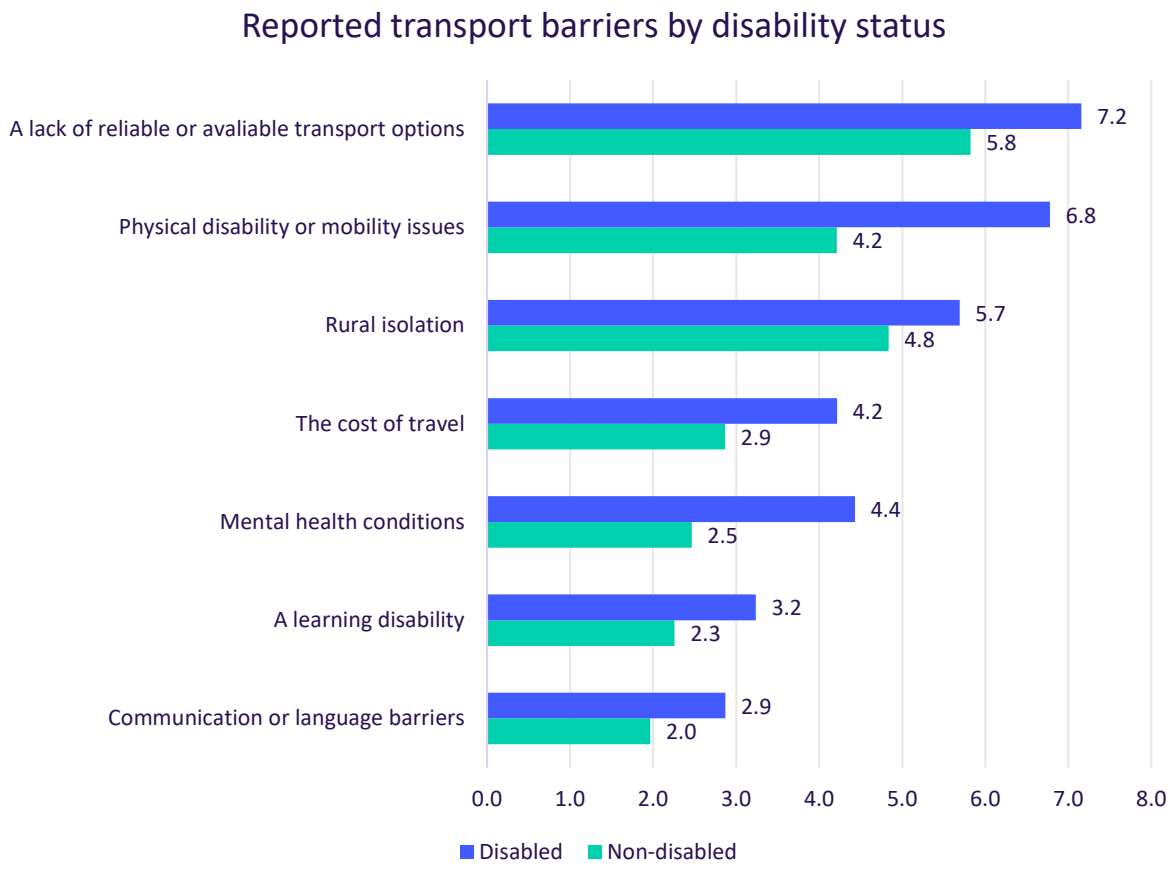


Figure 111: Transport barriers

What improvements people want

Respondents most frequently called for more direct and reliable public transport services to healthcare facilities. Improved parking provision, better coordination between transport services, clearer travel information and enhanced support for disabled users and carers were also widely requested. Reducing the cost of travel and improving access to specialist transport were identified as additional priorities.

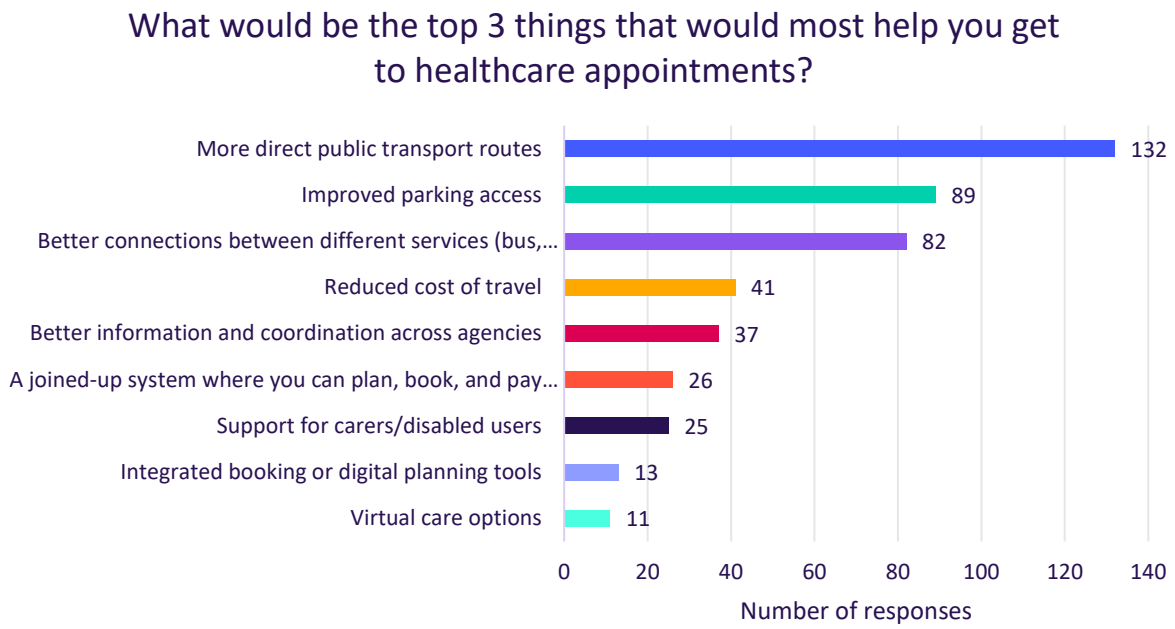


Figure 112: What would help access healthcare appointments

Responses show a mixed picture of support needs. The most common response was that no additional help is needed, suggesting many respondents are confident finding or booking travel independently. However, a substantial number identified specific improvements that would make this easier.

Paper timetables or printed leaflets were the most frequently requested form of support after this, highlighting the continued importance of non-digital options. Easier-to-use digital tools and websites were also widely requested, indicating that while many people use online tools, usability remains a barrier for some.

Smaller numbers of respondents said that phone helplines, in-person support at clinics or hubs, or advice from GPs and NHS staff would help. Community organisations were mentioned least often.

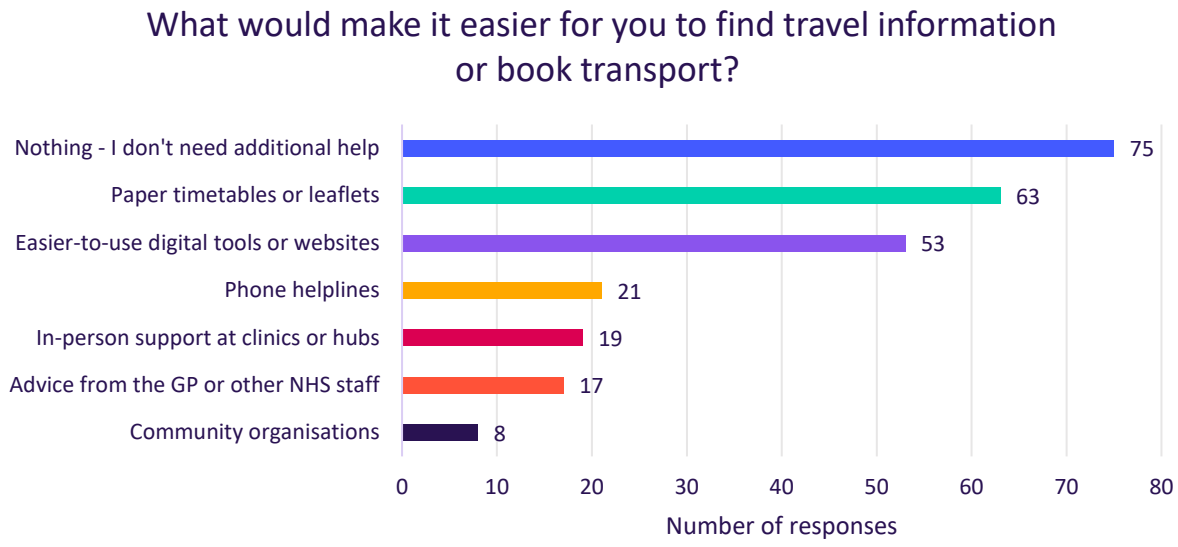


Figure 113: What would make it easier to find and book transport

Qualitative insights: Lived experience of travelling to healthcare

Primary and community care

Travelling to primary and community healthcare services was generally perceived as easier than accessing secondary or tertiary care across NHS Forth Valley. Many respondents described GP practices, pharmacies and dentists as being relatively close to home, particularly in more urban areas such as Falkirk, Stirling and Alloa.

> "Usually, I walk to the GP surgery or pharmacy."

However, despite this more positive overall picture, significant challenges remain for particular groups. Respondents with mobility issues, long-term conditions, or caring responsibilities reported ongoing difficulties reaching even local services.

> "Without access to a car & because access to public transport requires a long walk - which I am unable to do, I'd find it virtually impossible to attend a health care appointment."

Rurality and local service availability also affected access to primary care. Respondents in smaller towns and rural areas described fewer local services, limited appointment choice, and greater reliance on transport.

> "Dollar is simply not set up for healthcare access for anyone who cannot drive a car. Especially the elderly."

For some, appointment timing compounded these issues, particularly where public transport did not align with urgent or same-day appointments.

> "When the GP service does a phone appointment and then they decide they want to see you in 15 and you don't feel well enough to drive to the practice."

Secondary and tertiary care

Distance to healthcare

Distance to hospital-based care was a recurring theme in qualitative responses. Many respondents highlighted the challenges of travelling to Forth Valley Royal Hospital (FVRH), particularly from Clackmannanshire and more rural parts of Falkirk.

> "Trying to reach Forth Valley Royal Hospital from the Braes area"

For some patients, specialist appointments located outside the Health Board area added further complexity, often involving longer journeys and additional transport changes.

"Travelling outside local health board area to access various appointments"

Respondents described how long travel distances increased fatigue, stress and costs, particularly for those attending repeated appointments or managing ongoing conditions.

Public transport

Public transport issues were one of the most frequently raised barriers to accessing healthcare. Respondents described services as indirect and infrequent. Infrequent services which often mean long wait times before or after appointments where a suitably timed bus is not available.

Indirect services and journey complexity

Many respondents reported needing to take multiple buses or trains to reach hospital appointments, increasing journey times and uncertainty.

"Hospital appointments a lot more effort if using bus - 4x time due as bus doesn't take a direct route. Need to go via town centre and change."

Complex journeys were seen as particularly challenging for older people, those with disabilities, or people attending early morning appointments.

"I suffer from social anxiety, changing buses and no direct routes can cause more stress and anxiety on top of anxiety already feeling going to appointment"

Infrequent or limited services

Infrequent services were commonly cited, particularly outside peak hours or in less urban areas.

"Local bus service is poor. Only comes at most hourly, and never on a Sunday."

Respondents noted that return journeys were often more problematic, leading to long waits after appointments and additional fatigue.

Parking at major hospitals

Parking at Forth Valley Royal Hospital was a major concern raised by respondents. Difficulties finding a parking space were frequently described as stressful and time-consuming.

"Parking at Forth Valley Royal Hospital is a nightmare for parking"

Several respondents reported building extra time into their journey solely to secure parking, adding to the overall burden of attending appointments.

"Need to go about 30 minutes early and hope a space becomes available."

Concerns were also raised about the distance from parking areas to hospital entrances, particularly for those with mobility issues.

Community transport and taxis

Community transport and taxi services were often described as unreliable, unavailable, or expensive. Respondents noted difficulties booking services, limited capacity, and long notice periods.

> "Phoning transport is a nightmare; I wouldn't get transport to GPs or dentist."

The cost of taxis was highlighted as a significant barrier, particularly for those on low incomes or requiring frequent hospital visits.

> "We mostly have to get a taxi, though very rarely a friend takes us."

Some respondents reported being unsure what options were available, suggesting a lack of clear information about transport support.

Patient transport

Patient transport services were mentioned mainly in relation to difficulties accessing them. Respondents described being ineligible, refused transport, or struggling with inflexible pick-up times.

> "Very few patients are allowed hospital transport. Even with disability and health problems you are not allowed hospital transport."

Fixed pick-up times and long waits were reported as problematic, particularly for people with health conditions that made waiting difficult.

Accessibility

Accessibility issues cut across many responses and affected multiple modes of transport. Key issues raised included:

- → Being unable to drive due to health conditions or disability
- → Long distances to bus stops or stations
- → Limited availability of wheelchair-accessible transport
- → Inflexibility of patient and community transport services
- → Difficulty accessing disabled parking at hospital sites

> "Limited vehicles with wheelchair access with Dial-a-Journey* and limited access to areas outwith Central Region"

* door-to-door transport and mobility service based in Stirling

Respondents highlighted how these barriers often combined, leaving them reliant on others for lifts or forced to miss appointments.

Additional impacts

Reliance on driving or lifts

A common impact of transport barriers was reliance on driving or lifts from friends and family. Many respondents stated they would be unable to attend appointments without access to a car.

> "If I didn't have someone to drive me to hospital appointments or admissions, I would have to get a very unreliable bus"

There was also concern about future ability to attend appointments as people age or if they become unable to drive.

> "Had to give up my car due to failing eyesight."

Time and financial impacts

Respondents described healthcare travel as time-consuming, often requiring time off work or a full day to attend short appointments.

> "Nearly 5 hours for a 17–20-mile journey there and back."

The financial burden of transport, particularly taxis, was also highlighted.

Missed or delayed appointments

Some respondents reported missing, delaying or cancelling appointments due to transport difficulties, cost, or lack of suitable options.

> "Often miss hospital appointments because it is too painful or nauseating to travel there comfortably."

Summary of insights for NHS Forth Valley

The transport challenges experienced by residents in NHS Forth Valley reflect a combination of service centralisation, uneven public transport provision and varying levels of car dependency across Falkirk and Clackmannanshire. While many people are able to access primary care locally with relatively short journeys, access to hospital-based services, particularly Forth Valley Royal Hospital (FVRH), presents more significant and persistent barriers. These challenges are most acutely felt by people without access to a private car, those with disabilities or long-term health conditions, older people, and carers.

↘ Centralisation of acute healthcare at Forth Valley Royal Hospital

The centralisation of acute and specialist services at Forth Valley Royal Hospital is a defining feature of Transport to Health in NHS Forth Valley. While the site benefits from good strategic road access, it generates long and complex journeys for many residents, particularly those travelling from Clackmannanshire, the Hillfoots towns and the outer parts of Falkirk. Public transport journeys to FVRH are often indirect, require multiple stages and can exceed an hour,

turning routine appointments into time-consuming and tiring experiences. This centralisation increases reliance on private cars and disadvantages those unable to drive.

↘ Contrast between primary and secondary care access

Access to primary and community healthcare is generally more straightforward, especially in urban areas such as Falkirk, Alloa and Stirling, where GP practices, pharmacies and dentists are often within walking distance or a short bus journey. However, this more positive picture masks ongoing issues for people with mobility problems, those living in smaller towns or semi-rural areas, and those requiring urgent or same-day appointments. For these groups, even short journeys can become challenging where walking distances are too long, or public transport does not align with appointment times.

↘ Public transport service limitations

Public transport service issues were among the most commonly cited barriers across qualitative responses. Indirect routes, infrequent services and poor alignment with appointment times, particularly early mornings, evenings and weekends, make public transport an unreliable option for hospital travel. Complex journeys involving multiple changes increase stress, uncertainty and fatigue, especially for older people, those with anxiety, or people managing ongoing health conditions. Return journeys were frequently described as particularly problematic, often involving long waits after appointments.

↘ High reliance on private cars and lifts

Private car use dominates healthcare travel in NHS Forth Valley, reflecting both the geography of services and limitations in public transport. Many respondents stated they would be unable to attend hospital appointments without driving themselves or relying on lifts from family and friends. This reliance raises concerns about future access to healthcare as people age, experience declining health, or lose the ability to drive, highlighting a growing vulnerability among older populations.

↘ Parking pressures at Forth Valley Royal Hospital

Parking at FVRH emerged as a significant and recurring issue. Respondents frequently described difficulty finding spaces, the need to arrive early to secure parking, and the stress associated with potentially missing appointments. For people with mobility issues, the distance between parking areas and hospital entrances further compounds the challenge, adding physical strain to already demanding journeys.

↘ Community transport and taxi constraints

Community transport and taxi services were seen as important alternatives but are currently constrained by limited availability, booking difficulties and cost. Respondents described services as unreliable, requiring long notice periods or being unavailable when needed. Taxi costs were highlighted as a particular burden for those on low incomes or attending frequent appointments, making these options unsustainable for regular healthcare travel.

↘ Patient transport capacity and eligibility

Patient transport services were commonly mentioned in relation to ineligibility or refusal, rather than positive experiences. Fixed pick-up times, long waits and limited capacity were seen as poorly suited to people with complex health needs. Where patient transport was unavailable, respondents were often forced to rely on unsuitable alternatives, such as public transport or expensive taxis, or to delay or miss appointments altogether.

↘ Accessibility and mobility barriers

Accessibility issues cut across all modes of transport. Being unable to drive, long distances to bus stops, limited wheelchair-accessible vehicles, inflexible transport services and difficulty accessing disabled parking were all highlighted. These barriers frequently interact, leaving disabled people and those with long-term conditions disproportionately affected and more likely to rely on others for transport or to experience missed care.

↘ Time, cost and health impacts

Although transport costs were not the primary barrier for most respondents, they had a substantial impact on a minority, particularly those reliant on taxis or travelling longer distances for hospital care. Time costs were more widely felt, with many respondents describing healthcare travel as taking several hours or requiring time off work for relatively short appointments. Long and stressful journeys were also reported to worsen symptoms for some patients, particularly those experiencing pain, fatigue or nausea.

Stakeholder engagement

Engagement with partner organisations identified widespread gaps in transport data, limited coordination between services, and ongoing funding pressures.

Several areas report weak governance arrangements and a lack of dedicated responsibility for transport planning. Rural connectivity remains a persistent issue, particularly for NHS Fife and East Lothian, with older and disabled people disproportionately affected by access and affordability problems.

While NHS Lothian has more established transport infrastructure and digital tools, reduced fleet capacity, sustainability pressures and limited alignment with Local Authorities were noted.

The Scottish Ambulance Service was identified as a key stakeholder in relation to non-emergency patient transport. Engagement was sought during the study period; however, it was not possible to secure input within the project timeframe.

Table 3: Findings overview

Group Engaged	Issues identified by group	Key headlines
NHS Assure	Major gaps in patient/staff travel data; missed appointment links; early-stage coordination	Data gaps Fragmentation Limited coordination
Falkirk Council	Bus-focused support; no community transport links; no health focus in strategy	Funding pressure Poor integration Limited data
NHS Fife	No dedicated transport lead; poor rural connectivity; developing travel strategy	Governance gaps Rural access issues Weak data
East Lothian HSCP	Older/disabled access challenges; high costs; poor cross-county links	Access challenges Affordability Service relocation impacts
NHS Lothian	Central transport hub; reduced fleet; weak LA coordination; good digital tools underused	Silo working Sustainability pressures Misinterpretation of data

Scottish Borders popup session

A total of 65 insights were gathered from 51 participants, including patients, visitors and staff, highlighting a wide range of experiences relating to travel to and from the Borders General Hospital in Melrose, Scottish Borders. Staff input was included in this session to complement patient perspectives, as hospital staff are frequent users of local transport and often reside within the hospital's catchment area, making them potential patients in the future.

Including staff also helped identify areas where patient and staff experiences overlap, and where improvements to transport provision could benefit both groups. Staff perspectives were not collected elsewhere in the study, as the primary focus for other engagement activities was on patient and community experiences.

What works well?

Many respondents value the availability of free or discounted travel, particularly concessionary card holders and railcards, which enable affordable access across Scotland. Those living locally or with access to a car generally report few issues, citing reliable journeys, good traffic flow in normal conditions, and positive experiences with patient transport services. Some participants highlighted the reliability of local bus services and welcomed existing overflow parking arrangements such as ‘park and walk’ options.

What could be better?

Significant challenges were raised around parking capacity, particularly at peak times, with overflow parking being distant and difficult for those with mobility issues. Staff working late shifts are especially affected by limited bus timetables, with the last bus departing before many shifts end. Public transport issues include long journey times due to connecting buses, cancelled routes, high costs for staff, poor waiting conditions in bad weather, and overcrowding. Concerns were also raised about misuse of disabled parking spaces and the impact of overflow parking on the surrounding village.

Opportunities for improvement

Improving local bus services emerged as the most consistent theme. Suggested actions include more direct routes from smaller towns and villages, extended operating hours, better communication of timetable changes, and more responsive engagement from the bus operator. Participants also proposed park-and-ride schemes, expansion or redesign of parking facilities, and improved management of disabled and staff parking. There is a clear need for more reliable community and voluntary transport options, particularly for elderly patients and those whose conditions are deteriorating.

Community transport operators

Interviews with community transport providers highlight their essential role in enabling access to healthcare in rural and semi-rural areas, alongside significant capacity and system-level constraints.

Borders Wheels one of the primary community transport providers across the Scottish Borders, covering a large rural area. Around half of all bookings are healthcare-related, reflecting limited local services and the need for long-distance travel to Edinburgh and Glasgow. Similar patterns are seen in Lothian, where community transport supports access to specialist hospital care over long distances.

Demand for healthcare transport is rising, often at short notice, particularly when patient transport services are unavailable. Limited public transport, especially at weekends, further restricts access, with some rural journeys to hospital taking several hours one way.

Providers identified common structural challenges, including digital exclusion, funding models that do not reflect true costs, fragmented coordination between the NHS, Local Authorities and transport providers, and constraints linked to insurance, licensing and unclear legislation.

Despite these pressures, community transport can offer strong value for money. In Lothian, a council taxi contract costing £98,000 annually was replaced by a community transport service costing £35,000, saving over £60,000 per year. However, providers stressed that clearer coordination, fairer funding and better integration with statutory services are essential if community transport is to meet growing healthcare demand.

Case study: Clackmannanshire

Clackmannanshire Council, in partnership with NHS Forth Valley and regional transport agencies, launched a pilot patient transport service aimed at improving access to healthcare at Falkirk Community Hospital (FCH). The initiative runs from October 2025 through March 2026, operating on Wednesdays.

The pilot seeks to improve hospital access for residents in FK10–FK14, particularly those facing cost, distance, or mobility challenges, while collecting feedback and usage data to inform potential future adjustments to the service.

The pilot is financed through a People and Place grant supported by the Scottish Government and administered by SEStran, reflecting a collaborative effort across health, transport planning, and local government bodies.

Service Model

- Direct Door-to-Door Bus Service: Patients are picked up from home and transported to FCH, then returned after appointments.
- Booking System: Seats are reserved via Order of Malta Dial-a-Journey by phone; the provider offers door-to-door assistance.
- Operating Hours: 08:30–17:30 on Wednesdays.
- Affordability: A £2 single fare per passenger, providing highly subsidised access.
- Accessibility: Mobility aids and disabled users are accommodated, and one carer may assist patients from the vehicle to their hospital department.

While the initiative is still in its pilot phase and overall usage is limited, it has the potential to support residents with restricted transport options, provide early insights into patient transport needs in semi-rural areas, and inform longer-term planning, including potential route or schedule adjustments if demand increases.

Problems, opportunities, issues and constraints (POIC)

Introduction

This section synthesises the quantitative evidence, travel-time modelling, socio-economic analysis, public consultation findings and emerging stakeholder insight to identify the key Problems, Opportunities, Issues and Constraints affecting Transport to Health across the SEStran region.

The POIC assessment provides a bridge between the descriptive evidence presented earlier in the report and the development of Transport Planning Objectives in the next phase. It organises the evidence into a clear structure that distinguishes between:

- Problems: current negative conditions that prevent the transport system from meeting user needs
- Opportunities: positive potential for improvement or innovation
- Issues: factors that require further consideration, analysis or resolution
- Constraints: fixed limitations (fiscal, legislative, geographic, operational) that shape what can realistically be taken forward

The assessment begins with a regional perspective, recognising the shared patterns that affect all four Health Board areas. It then identifies Board-specific variations, reflecting the distinct geography, transport provision and healthcare configuration within NHS Lothian, NHS Fife, NHS Borders and NHS Forth Valley.

This structured understanding of existing barriers and future potential will inform the development of Transport Planning Objectives and support the generation of a longlist of options in subsequent stages.

Problems

Problem 1: Public transport journeys to hospital care are long, indirect and significantly slower than car travel

Travel-time modelling shows that public transport journeys to hospital are typically two to four times longer than equivalent car journeys. Many hospital trips require multiple interchanges, long walking distances and extended waiting times, particularly for people travelling from rural areas, small towns and outer urban communities. These journey characteristics create stress, increase fatigue and reduce the practicality of attending appointments by public transport.

Problem 2: People without access to a car face disproportionate barriers to healthcare access

Households without access to a private car are heavily concentrated in more deprived areas, where public transport options are often limited or indirect. These residents are more exposed to long

journey times, higher cumulative costs and unreliable services. This reinforces existing health and social inequalities and increases reliance on informal support such as lifts from family or friends.

Problem 3: Transport barriers contribute to missed or delayed healthcare appointments

Transport barriers contribute to missed or delayed healthcare appointments, particularly for outpatient and same-day care. Evidence from the public consultation shows that between one third and almost half of respondents across the region have experienced transport-related non-attendance, with the highest rates reported in NHS Fife. Delayed services, infrequent timetables, parking pressures and accessibility barriers are recurring contributing factors.

Problem 4: Accessibility barriers limit the suitability of public transport for some users

Disabled people, older adults and those with long-term health conditions face additional barriers, including long walks to stops, inaccessible infrastructure, difficulty transferring between services and limited availability of wheelchair-accessible taxis. These barriers make public transport unsuitable for some users, even where services exist.

Opportunities

Opportunity 1: Better alignment between healthcare planning and transport provision

There is scope to systematically align appointment scheduling, clinic locations and service patterns with existing transport networks. Improved coordination between Health Boards, transport authorities and operators could reduce journey complexity and improve reliability for patients.

Opportunity 2: Greater use of local and community-based healthcare provision

Expanding the use of community hospitals, local clinics and outreach services for appropriate outpatient activity could reduce the need for long-distance travel to acute hospitals, particularly for routine follow-up appointments.

Opportunity 3: Improved integration of transport information and booking

Clearer, more consistent information on travel options, eligibility for support and reimbursement, and available community transport could reduce uncertainty and stress for patients. There is potential to integrate transport information more effectively into appointment communications and digital platforms.

Opportunity 4: Strengthening community and demand-responsive transport

Community transport and demand-responsive services already play a critical role in filling gaps where public transport is limited. With better coordination, visibility and support, these services could be scaled or targeted to support healthcare access more effectively, particularly in rural and semi-rural areas.

Opportunity 5: Contributing to wider policy goals

Improving Transport to Health supports the Scottish Government's key priorities, as highlighted by the First Minister. This includes reducing health inequalities, enhancing access to healthcare, strengthening local and community-based services, and promoting sustainable transport to help achieve net-zero emissions. Targeted improvements in patient access and journey reliability can therefore advance both national objectives and regional Health Board goals for equitable, efficient, and sustainable service delivery.

Opportunity 6: Digital delivery

For selected appointment types, such as routine follow-ups or advisory consultations, virtual or hybrid delivery could reduce the need for some in-person journeys. Offering an online consultation option at the point of booking, where clinically appropriate, may help mitigate complex or lengthy travel, particularly in rural areas.

This approach would need to balance clinical suitability and patient preference, while avoiding digital exclusion. Used selectively, virtual appointments could complement wider Transport to Health improvements by reducing avoidable journeys without replacing in-person access.

Issues

Issue 1: Hospital location, appointment timing and transport service patterns are misaligned, increasing journey complexity and non-attendance risk

Evidence from travel-time modelling and the public consultation shows that hospital appointments are frequently scheduled at time when direct public transport services are limited, infrequent or unavailable. Many respondents described journeys requiring multiple interchanges, early arrival or long waiting times due to hourly services, and uncertainty around return travel. This misalignment increases journey complexity, raises the risk of lateness or cancellation, and disproportionately affects people attending regular outpatient appointments, those without access to a car and people with mobility or health-related constraints.

Issue 2: Information about transport options and support is fragmented and inconsistent

Patients often rely on informal sources such as online maps or personal knowledge to plan healthcare journeys. Information on community transport, eligibility for patient transport or reimbursement, and accessible options is not consistently provided or easy to understand. This creates uncertainty, particularly for first-time or infrequent hospital users. This reflects a wider absence of a shared, system-wide approach to Transport to Health information and responsibility.

Issue 3: The role of community transport is critical but not fully integrated into system planning

Community transport providers are filling important gaps, yet their role is often reactive, under-recognised and inconsistently linked to NHS transport planning. Further consideration is needed on how these services can be better coordinated, funded and integrated alongside public transport and non-emergency patient transport.

Issue 4: Parking pressures at major hospitals continue to influence travel behaviour

Limited and unreliable parking availability at acute hospitals contributes to stress, late arrivals and continued car dependency. While parking is not strictly a transport service issue, it strongly shapes mode choice and patient experience and requires consideration alongside wider Transport to Health measures.

Constraints

Constraint 1: Geographic dispersion and rurality

The region's settlement pattern includes extensive rural and semi-rural areas where low population density limits the viability of frequent fixed-route public transport services. These geographic realities constrain the extent to which conventional services can meet all healthcare travel needs.

Constraint 2: Centralisation of acute and specialist healthcare services

The concentration of secondary and tertiary care in a limited number of hospital sites is driven by clinical and operational requirements. While necessary, this centralisation creates unavoidable longer travel distances for some patients.

Constraint 3: Funding and resource limitations

Public transport services, community transport and NHS patient transport all operate within constrained funding environments. This limits the scope for rapid or large-scale service expansion without clear evidence of benefit and partnership funding arrangements.

Constraint 4: Legislative and operational boundaries

Transport planning, service delivery and healthcare commissioning sit across multiple organisations with different statutory responsibilities, funding cycles and priorities. These institutional boundaries constrain how quickly and seamlessly change can be implemented.

Transport planning objectives

The Transport Planning Objectives set out in *Table 4* (overleaf) translate the evidence presented in this Case for Change into a focused set of outcomes to be achieved through future intervention. They are derived directly from the Problems, Opportunities, Issues and Constraints identified across the SEStran region and reflect both shared regional challenges and variation between Health Board areas.

These objectives will provide the framework for option generation, sifting and appraisal in subsequent stages of developing a Regional Transport to Health Strategy.

Table 4: High-level Transport Planning Objectives

Ref	Transport Planning Objective	Specific	Measurable	Attainable	Relevant	Timely
TPO1	Reduce journey time, interchange complexity and uncertainty for secondary and tertiary healthcare trips	Reduce public transport journey times, number of interchanges and excess waiting time for access to major hospital sites across the SEStran region.	Average public transport journey times to key hospital sites; proportion of journeys requiring two or more interchanges; reliability metrics derived from accessibility modelling and operator data.	Delivery dependent on partnership working with operators and local authorities. Achievability to be tested through option development and appraisal.	Directly linked to identified problems of long, indirect hospital journeys and transport-related non-attendance. Supports NTS2 priority on reducing inequalities.	Quantified improvement ranges and delivery timeframes to be defined at options appraisal and strategy stage.
TPO2	Improve reliable and affordable access to healthcare for people without access to a private car	Improve public, community and supported transport connectivity for areas and groups with low car ownership.	Proportion of population within defined public transport travel time thresholds to key hospital sites; reduction in self-reported cost barriers in follow-up surveys.	Dependent on funding, service integration and partnership arrangements. Feasibility to be explored during appraisal.	Addresses documented inequities affecting deprived areas, rural communities and non-drivers. Aligns with Fairer Scotland Duty and NTS2 reducing inequalities objective.	Baseline confirmation required before setting percentage improvement targets in subsequent strategy phases.
TPO3	Improve the accessibility and usability of transport for disabled people, older people and those	Reduce physical, sensory and cognitive barriers associated with	Increase in accessible journey options; reduction in reported	Influenced by infrastructure investment cycles, fleet renewal and	Supports Equality Act 2010 obligations and identified	Improvement benchmarks to be determined following accessibility audits and

Ref	Transport Planning Objective	Specific	Measurable	Attainable	Relevant	Timely
	with long-term conditions	healthcare journeys, including walking distance, step-free access and vehicle accessibility.	accessibility barriers; availability of wheelchair-accessible or supported transport services.	service design. Detailed feasibility assessment required at options stage.	accessibility challenges in the POIC analysis.	further stakeholder engagement.
TPO4	Reduce transport-related missed and delayed healthcare appointments	Improve alignment between appointment scheduling and transport service provision and reduce transport-related non-attendance.	Reduction in self-reported transport-related missed or delayed appointments; NHS-recorded non-attendance attributed to transport factors where data allows.	Achievable through coordinated service planning and reliability improvements, subject to data availability and institutional collaboration.	Responds directly to survey findings showing significant transport-related non-attendance across the region. Supports NHS efficiency and patient outcomes.	Reduction targets to be defined once improved data linkage and baseline confirmation are established.
TPO5	Improve clarity, coordination and accessibility of transport information and support	Integrate transport information within healthcare communications and improve awareness of community transport, reimbursement and eligibility processes.	Increased inclusion of transport information in appointment communications; user-reported ease of journey planning; uptake of coordinated information platforms.	Dependent on NHS digital system integration and inter-agency coordination. Practical constraints to be examined at implementation stage.	Aligns with Transport to Health Delivery Plan commitments regarding improved coordination and information provision.	Phased implementation expected alongside digital system updates; detailed timeframes to be defined in delivery plan.
TPO6	Integrate and enhance community and demand-	Improve formal coordination	Increased coordinated	Subject to funding models, governance	Supports duties under the Transport	Improvement targets and service coverage

Ref	Transport Planning Objective	Specific	Measurable	Attainable	Relevant	Timely
	responsive transport to support healthcare access	between NHS Boards and community or demand-responsive transport providers and expand coverage where fixed-route services are not viable.	bookings; reduction in unmet trip requests; expanded geographic coverage of community or demand-responsive transport services supporting healthcare trips.	arrangements and operator capacity; to be assessed through detailed option appraisal.	(Scotland) Act 2019 and addresses identified gaps in rural and semi-rural connectivity.	benchmarks to be defined following appraisal and partnership agreements.
TPO7	Reduce unnecessary car dependency and improve system efficiency in healthcare travel	Encourage modal shift for appropriate healthcare trips, reduce parking pressure at major hospital sites and support more efficient use of transport resources.	Changes in mode share for healthcare journeys; reduction in parking demand at key hospital sites; estimated reduction in transport-related emissions where feasible.	Long-term behavioural and system change requiring coordinated investment and policy alignment; feasibility to be examined through appraisal.	Supports NTS2 climate and health priorities, Regional Bus Strategy objectives and wider net zero commitments.	Mode shift and efficiency benchmarks to be established in the subsequent strategy phase, aligned with regional carbon and transport targets.

Equality Impact Assessment (EqIA)

January 2026

Assessment stage: Case for Change (policy development stage)

Summary

This Equality Impact Assessment (EqIA) is undertaken at the Case for Change stage of SEStran's development of a Regional Transport to Health Strategy. The assessment responds to the Scottish Transport Appraisal Guidance (STAG) requirement to consider equality and socio-economic impacts from the earliest stage of policy development.

STAG requires that EqIA (and other impact assessments) align with each appraisal stage (Case for Change, options, detailed appraisal), but it does not prescribe a specific EqIA document format or template.

This EqIA summarises the equality evidence and baseline, assesses the likely impacts on protected groups and records mitigation options. It outlines how findings will influence the options available at the full Strategy detailed appraisal and consultation stage.

Key findings:

The protected groups most affected include:

- Disabled people and those with long-term health conditions
- Older adults (particularly those aged 75+)
- People without access to a private car
- Carers (predominantly women)
- People living in rural and remote areas
- People living in areas of high deprivation
- Pregnant people

Primary equality concerns identified:

1. Accessibility barriers: long or complex public transport journeys to hospital care compound accessibility barriers for disabled people and those with mobility impairments, creating disproportionate disadvantage
2. Gender dimension to care: 73% of survey respondents providing care when travelling to healthcare appointments are women, reflecting broader patterns of unpaid care responsibility that constrain travel flexibility and compound disadvantage
3. Spatial deprivation overlap: communities with highest deprivation show lowest car access and longest public transport journey times to hospital care, compounding health inequalities

4. Age-related vulnerability: older adults (75+) experience multiple intersecting barriers including reduced driving confidence, accessibility challenges, lower digital confidence, and sensitivity to service frequency or reliability changes
5. Rurality and remoteness: remote rural residents face public transport journey times to hospitals of four to six times longer than urban residents, with significantly reduced service alternatives
6. Cost accumulation: while not universally reported as a barrier, cost of transport can be significant for people attending frequent appointments (oncology, dialysis, physiotherapy) and impacts disproportionately on low-income households

Main aspects of the Case for Change that address these concerns:

- Explicit recognition in Transport Planning Objectives (TPO2, TPO3, TPO5) of accessibility, car-free access and support for disabled and older people
- Engagement with disabled people's perspectives
- Gender-disaggregated data on carers captured in survey
- Distributed analysis by deprivation decile and urban-rural classification
- Community transport operators explicitly engaged and their role recognised
- Cross-sectoral partnership approach involving NHS, local authorities and transport providers

SECTION 1: Policy overview and legislative context

Purpose and scope of policy

The Transport to Health Case for Change establishes an evidence base for developing a Regional Transport to Health Strategy for the South East of Scotland (SEStran region). The strategy will address how people travel to primary, secondary and tertiary healthcare services across eight local authority areas encompassing NHS Lothian, NHS Fife, NHS Borders and NHS Forth Valley.

The Case for Change maps existing access patterns and barriers to healthcare and identifies transport-related missed and delayed appointments. The process documents lived experience of diverse population groups and sets Transport Planning Objectives to guide future intervention development. This establishes an evidence base for future development stages aligned with Scottish Transport Appraisal Guidance (STAG).

Legislation and policy

Under the Equality Act 2010 (Public Sector Equality Duty) SEStran, as a public body, has a general duty to eliminate unlawful discrimination and harassment, advance equality of opportunity, and foster good relations between people who share a protected characteristic and those who do not.

Protected characteristics under the Equality Act 2010 include: age, disability (including long-term health conditions), gender reassignment, marriage and civil partnership, pregnancy and maternity, race (including ethnicity and national origin), religion or belief, sex (including gender), sexual orientation.

The Fairer Scotland Duty requires public bodies to consider how policies and decisions can reduce inequalities of outcomes. The duty particularly focuses on people with protected characteristics and people experiencing socio-economic disadvantage, defined as those experiencing low income, low wealth, low employment, area deprivation and social isolation.

Sections 120-121 of the Transport (Scotland) Act 2019 place specific duties on NHS Health Boards to have regard to economic, social and environmental wellbeing in non-emergency patient transport contracts, work with community transport organisations, and publish annual reports on compliance with these duties.

Additionally, National Transport Strategy 2 (NTS2) commits to improving sustainable access to healthcare, with explicit focus on older and disabled people linked to:

- Priority 1: Reduce inequalities
- Priority 4: Improve health and wellbeing
- Specific objective: Improve sustainable access to healthcare facilities for staff, patients and visitors

Alongside this, in 2024 Scottish Government published its Transport to Health Delivery Plan, which contains commitments to:

- Improve cooperation and coordination between transport and health systems, with RTPs required to convene multi-agency Transport to Health groups
- Health Boards and RTPs must work together on equalities in patient transport
- Ensure patients have access to information on transport, community transport, and reimbursement
- Review Scottish Ambulance Service Equalities Impact Assessment
- Integrate transport information into NHS inform app and Traveline
- Support care closer to home and digital services where appropriate

Scottish Transport Appraisal Guidance

STAG applies broadly to all stages in public sector-led strategy development processes, including for the Case for Change, primarily to identify distributional impacts and equality concerns to inform problem definition. At option generation and sifting, STAG requires an assessment of how options support or hinder equality objectives. Detailed appraisal incorporates an EqIA that quantifies equality impacts and identifies appropriate mitigations.

Over the past five years, significant developments in Scottish Government policy, guidance, and legislation have reshaped expectations for how equality and socio-economic impacts are assessed in transport strategy development. This EqIA reflects updated best practice.

Fairer Scotland Duty Guidance updated in 2023 emphasises integration with the Public Sector Equality Duty and other equalities duties. This EqIA treats socio-economic disadvantage (deprivation,

transport poverty, car access) as a central equality concern, not just wider context. Links to Fairer Scotland Duty are woven throughout this EqIA.

Since the Fairer Scotland Duty 2023 guidance, bodies are now encouraged to draft assessments at early stages, including at the Case for Change stage. Accordingly, this EqIA should be seen as a 'live' document, revised at each STAG stage.

EqIAs for strategy development in earlier years often separated protected characteristics analysis from socio-economic disadvantage. These issues are now interlinked, with deprivation and socio-economic disadvantage treated as equal to disability, age or gender. For example, earlier formats of EqIAs would highlight that some people in deprived areas cannot access cars and this is a transport problem addressed by better public transport. The approach of this EqIA is to highlight that those in the most deprived areas have lowest car access, as well as the longest public transport journey times to hospital, creating compounded health inequality. This is an equity issue requiring targeted intervention for lowest-income households, not necessarily more public transport.

This EqIA frames Transport to Health improvements as health inequality interventions, not just transport or service delivery issues. Intersecting disadvantages are also flagged, where age, disability, locality (e.g., living rurally) and low-income compound inequalities. This EqIA considers those cumulative impacts.

SECTION 2: Information about the affected population

Demographic profile of the region

Population:

- Total population: 1.6+ million across eight local authority areas
- Geographic diversity: dense urban (Edinburgh), expanding commuter towns, coastal settlements, remote rural communities

Age distribution:

- Scottish Borders and Clackmannanshire have the highest proportion of residents aged 75 or over
- Edinburgh has the youngest age profile with high proportion of working-age adults
- Midlothian, Falkirk, West Lothian have younger distributions reflecting continued residential expansion
- National projections show significant growth expected in Edinburgh, Midlothian, East Lothian to 2032, with stagnation or decline in many rural areas

Implications for Transport to Health

Older populations in rural areas experience greater healthcare need, reduced driving confidence or ability, higher sensitivity to service changes, with compounded accessibility barriers.

Rapid growth areas, such as Midlothian, have increased healthcare demand without corresponding transport infrastructure expansion.

Older adults are also among the highest users of NHS services. While the over-75s make up a relatively small share of the population across Scotland, they account for a disproportionately large share of GP consultations, outpatient referrals and emergency and elective admissions.

Disability and long-term health conditions

A notably high proportion of the population in the area of NHS Fife have long-term health conditions or disabilities (over 4% above the regional average).

40% of all those responding to surveys conducted for the Case for Change reported having a long-term health condition or disability (compared to 23% in general population), and 21% provide unpaid care.

People living with long-term conditions are high users of healthcare, and prevalence of limiting long-term conditions rises sharply with age, meaning that older and disabled people are both more likely to need regular contact with NHS services and more affected when transport barriers limit access.

Access and transport needs

People with disabilities are more likely to have fewer independent travel options. They are also more likely to be unemployed, partly due to transport difficulties. However, people with disabilities also make higher proportion of journeys to healthcare compared to general population

Additional barriers include:

- Inconsistent patient escort rules across transport services
- Lack of accessible taxis (many tied into school transport contracts)
- Long walking distances between interchanges
- Physical demands of multi-stage public transport journeys

Transport poverty and deprivation

Car ownership patterns show 75% of households have access to a car across the region, with lowest levels in Edinburgh (63%) and the highest in Midlothian and Borders (86%). 25% of households have no car access.

There is socio-economic variation within this spread. Areas with the highest levels of deprivation have significantly lower car ownership or access than affluent areas, whilst vulnerable households in urban areas retain cars despite financial hardship, as they are unable to rely on public transport alternatives.

With 25% of the population relying entirely on public, community or informal transport for healthcare, people in deprived areas face compounded burdens: those most likely to have complex health needs are also least likely to have car access.

Public transport journey times that are two to four times longer than car journeys when accessing primary care, or three times longer to visit a hospital, become material barriers without access to a car.

Rurality is not the only issue: 91% of people with high health deprivation and poor connectivity live in urban or semi-urban settings. Particularly affected areas include urban peripheries (e.g., south Edinburgh, parts of West Lothian), coastal towns (e.g., Leven in Fife), and rural pockets with high deprivation (Clackmannanshire, parts of Borders).

Deprivation is already associated with poorer health outcomes. Transport barriers compound this by increasing missed appointments, delaying care-seeking, creating stress and anxiety and reducing opportunities for preventive or screening appointments.

Gender and unpaid care

21% of survey respondents provide unpaid care. Most carers in the region are female (73%), which matches the number of women responding to the survey who provided care when travelling to healthcare appointments.

Carers frequently reported time pressures, reliance on others for lifts, and complexity of coordinating transport around caring responsibilities. Specific barriers for carers include difficulty in arranging and affording dual transport (for both carer and the cared-for person) and limited flexibility in appointment timing to accommodate other caring responsibilities. Survey respondents also experienced stress and anxiety managing long, complex or uncertain journeys.

Previous work by the Mobility and Access Committee for Scotland (MACS, 2019) highlights that not providing free transport for a carer to accompany the patient can be a false economy, leading to greater costs for the healthcare service.

Ethnicity

There remains a lack of specific data on transport barriers for ethnic minority communities. Most (90%) respondents to the survey provided ethnicity data, most of whom (97%) identified as white (Scottish/British/other white). Less than 1% were from Asian, African and other ethnic groups and were underrepresented compared to the regional population, which is 4% Asian, 2% African and 2% from other ethnic groups.

Rural and remote communities

In remote rural areas the average public transport journey time to the GP is 24 minutes (three times longer than in urban areas).

Parts of Clackmannanshire, Borders, rural Fife experience public transport journeys of 50 minutes or longer to hospital, with no feasible connections. Where there is bus provision in semi-accessible, rural areas, this is often only daytime or on weekdays, limited by population density that impacts the viability of frequent fixed-route services. Large rural areas may rely on a single community transport provider (e.g., Borders Wheels for the entire Scottish Borders area).

There is also limited rail access for many communities, with services having reduced over time in some areas.

Compounding issues in rural areas include the higher proportion of older adults and lower car ownership in some locations, and smaller or small numbers of GP practices due to GP mergers or relocations. Informal support networks are also more limited in areas where populations are not growing.

Young adults and sexual and gender minorities

There remains limited data on how young adults experience transport barriers to healthcare (e.g., sexual health services, mental health support). Whilst there is no specific evidence on barriers for LGBTQ+ people, this group may need to travel further for specialist services (e.g., gender identity services). They may also anxiety in accessing healthcare in unfamiliar settings, and intersectional disadvantages (being also young, poor or in a rural area). Future strategy development stages should seek to evidence potential barriers for this group.

SECTION 3: Equality impacts for the different groups

This section outlines the inequalities faced by those with protected characteristics and wider groups that the Transport to Health Strategy could address.

Age: older adults (65+, particularly 75+)

↘ Potential impacts

Older adults not only face greater mobility and accessibility challenges, they are also the group most likely to require frequent GP, outpatient and hospital care, so any increase in journey time or complexity has a disproportionate impact on their ability to access the NHS.

Mobility and accessibility challenges

- ↘ Older adults often experience reduced mobility, hearing loss, vision changes, cognitive changes.
- ↘ Long walking distances between interchanges, steep gradients, poorly maintained bus stops, difficulty boarding or alighting buses all reported as barriers.
- ↘ Without accessible transport redesign, barriers may worsen for frailer older people, increasing reliance on informal support or leading to missed appointments.

Digital exclusion and information barriers

- ↘ Older people often have lower digital confidence, with greater reliance on paper information, staff advice, personal knowledge rather than digital tools.
- ↘ If transport information is primarily delivered via apps or digital platforms without parallel non-digital routes, older people may lack information needed to plan journeys.

Service reliability and frequency sensitivity

- ↘ Older adults are more affected by service changes, closures, or frequency reductions. This Scottish Borders disproportionately affects population with 29% aged 65+
- ↘ Planned bus service changes could disproportionately impact older people, with no evidence of equality impact assessment of the proposed changes.

Health vulnerabilities and appointment frequency

- ↘ Older adults attend healthcare more frequently, compounding impact of transport barriers.
- ↘ There is a strong correlation between missing appointments and worsened health outcomes.
- ↘ Transport barriers may lead to missed preventive and screening appointments, and acute deterioration.

Driving cessation

- ↘ Some older adults cease driving due to age or health. Forced car ownership creates unexpected vulnerability.
- ↘ Rapid loss of familiar travel modes with inadequate public transport alternatives creates crisis situations for older people.

↘ Mitigation

Transport Planning Objectives (TPO3, TPO7) recognises older people as a priority group. The evidence base maps age-related deprivation and travel times, cross-referenced with literature on older people's transport needs.

Demand-responsive transport (DRT) pilots that are ongoing (e.g., Scottish Borders, Fife) could address some issue.

↘ Further evidence needed

- ↘ Impact of specific proposed interventions on journey times or complexity for older people
- ↘ Accessibility of different transport modes (bus, rail, community transport, taxi)
- ↘ Feasibility of demand-responsive services for older people across region

Disability and long-term health conditions

↘ Potential impacts

Disabled people and those with limiting long-term conditions typically have higher and more frequent contact with healthcare services than non-disabled people, including repeated outpatient appointments and ongoing primary care, which makes accessible and reliable transport to health particularly critical for this group.

Physical accessibility barriers

- ↘ Limited accessible taxis for wheelchairs (many in school transport contracts), poor accessibility at bus stops, inaccessible interchanges
- ↘ Mobility limitations include long walking distances between connecting buses, difficulties boarding or alighting
- ↘ Without systematic accessibility audit and redesign, disabled people may face worsening barriers if services change

Sensory barriers

- ↘ Poor audio announcements, crowded or noisy interchanges are more significant barriers for those with hearing loss
- ↘ Vision loss leads to difficulty reading timetables, affected more so by poor lighting at bus stops, compounding navigation challenges
- ↘ No specific data on prevalence of sensory barriers

Cognitive and mental health barriers

- ↘ Complexity of multi-stage journeys, need to read multiple timetables, anxiety in unfamiliar environments or linked to long or uncertain journeys, which information improvement alone may not address there is a need for simplified journeys and consistent service

Carer support gaps

- ↘ Inconsistent patient escort rules across transport services
- ↘ Health conditions affect toilet access needs (breaking journeys)
- ↘ Formal carer support (e.g., to accompany patient) often not funded
- ↘ Disabled people may be unable to travel independently, with reliance on informal carers (often family, frequently women) increasing vulnerability

Frequent appointments and cumulative burden

- ↘ Regular outpatient care (oncology, dialysis, physiotherapy) compounds impact of long journeys
- ↘ Fatigue, stress accumulation, cost burden all multiply with frequency
- ↘ Disabled people with complex needs may face greatest cumulative burden

↘ Mitigation

TPO3 explicitly targets accessibility for disabled people and Case for Change process engaged with disabled people's organisations and captured lived experience.

Recognition in Case for Change of need for personalised support and potential for demand-responsive transport and door-to-door services.

↘ Further evidence needed

- ↘ Systematic accessibility audit of current transport network
- ↘ Impact assessment of specific proposed interventions on different disability groups
- ↘ Cost-benefit analysis of accessibility improvements vs. cost of missed appointments
- ↘ User-led design process for accessible services

Gender (with focus on unpaid carers and women)

↘ Potential impacts

Unpaid carers are frequent users of NHS services in their own right and play a central role in enabling the person they care for to attend appointments, with survey evidence suggesting that almost all carers have supported someone to attend at least one hospital appointment in the last year.

Women and pregnant people are more likely to be travelling with prams, young children or pregnancy-related mobility and comfort needs, and are simultaneously required to attend frequent maternity appointments, which makes them especially vulnerable to long, complex or inaccessible public transport journeys.

Unpaid care responsibilities and time poverty

- ↘ Most people providing care when travelling to healthcare are women
- ↘ Time pressures, complexity of coordinating multiple journeys, stress
- ↘ Care responsibilities often constrain flexibility in timing of healthcare journeys
- ↘ Without childcare-friendly services or support for carer transport, gendered care burden intensifies

Transport cost burden

- ↘ While not universally reported, cost barriers are significant for some
- ↘ Cost burden multiplies for carers accompanying patients on regular journeys
- ↘ Women carers from low-income backgrounds are most affected

Safety and personal security

- ↘ Women using public transport may experience or fear sexual harassment or assault
- ↘ Waiting at isolated bus stops, travelling at off-peak times
- ↘ No specific data on safety concerns

Gendered health conditions

- ↘ Pregnancy and maternity-related appointments often require specialist travel
- ↘ Miscarriage or termination services may require confidential travel options
- ↘ Unequal access to women's health screening services
- ↘ Limited consideration to date of reproductive health appointment journeys

↘ Mitigation

Case for Change disaggregates gender data on carers and carers' perspectives are explicitly cited.

There is recognition of carers' distinct transport needs in TPO5 (coordination and clarity of information).

Potential for flexible or demand-responsive transport to accommodate caring responsibilities

↘ Further evidence needed

- ↘ Specific consideration of how proposed interventions will support carers.
- ↘ Engagement with women's health services on transport barriers to appointment attendance.
- ↘ Safety audit and mitigation strategies for women using public transport.

Rurality and geographic isolation

↘ Potential impacts

Journey time and service frequency

- ↘ Public transport journey to hospital 50-90+ minutes with multiple interchanges required
- ↘ Service frequency is often single daily service or inter-daily services
- ↘ Without targeted intervention, rural residents remain locked out of timely hospital access

Structural service gaps

- ↘ Fixed-route services often not viable in low-density areas
- ↘ Community transport capacity constraints (e.g., Borders Wheels serves entire Scottish Borders)
- ↘ Demand-responsive transport limited and often expensive
- ↘ Service gaps may widen if public transport operator reduces services further

Appointment scheduling misalignment

- ↘ Early-morning hospital appointments cannot be reached by public transport (no early buses)
- ↘ No weekend services and afternoon appointments are also difficult
- ↘ Rural patients are forced to miss or reschedule appointments with no choice about timing

Informal support dependency

- ↘ Rural residents often rely on lifts from family or friends

- Limited taxi capacity creates vulnerability (when told to get a taxi, research survey respondents report there are sometimes none available)
- Dependency on informal support creates stress and unpredictability

Compounding disadvantages

- Rural areas show higher proportion of older adults in some locations
- Rural deprivation pockets have lower car ownership
- GP closures (e.g., Chirnside, Coldingham) push primary care further away

Mitigation

Case for Change has systematically mapping of journey times by urban-rural classification, origin-destination modelling showing spatial patterns of disadvantage.

Community transport operators have been explicitly engaged.

Demand-responsive transport trials are ongoing.

TPO6 recognises the need for different solutions in rural vs. urban contexts (TPO6).

Potential opportunity for local and community-based care to reduce travel distance (TPO Opportunity 2).

Further evidence needed

- Detailed cost-benefit analysis of community and demand-responsive transport expansion
- Modelling of impact of potential public transport reductions on rural communities
- Feasibility assessment of appointment scheduling aligned with transport availability

Deprivation and socio-economic disadvantage

Potential impacts

People in more deprived communities experience a higher burden of disease and poorer health outcomes, which leads to higher need for NHS care; transport barriers in these areas therefore translate directly into unmet need and increased risk of avoidable deterioration.

Transport cost accumulation

- Transport costs affect attendance at appointments
- For frequent appointments (oncology, dialysis, physiotherapy), costs accumulate
- Public transport fares, rail and taxis compound costs for those with accessibility needs

- ↘ Lack of multimodal ticketing means each leg costs separately
- ↘ People from low-income backgrounds attending frequent appointments face cumulative financial barriers

Forced car ownership or inadequate alternatives

- ↘ Deprived communities have lower car ownership (no choice) and others face forced car ownership (creating a debt trap). Either scenario limits resources for healthcare: no car = long journeys; forced car = financial vulnerability
- ↘ Further financial hardship for already vulnerable populations

Accessibility of reimbursement schemes

- ↘ NHS reimbursement process complex, requires payment upfront then reimbursement
- ↘ Many healthcare professionals unable to advise on access or eligibility
- ↘ People without savings are unable to afford upfront costs and miss opportunities for reimbursement

Compounding health inequalities

- ↘ Deprivation already associated with poorer health outcomes
- ↘ Transport barriers prevent access to preventive and screening for early intervention care
- ↘ Missed appointments correlate with worse health outcomes
- ↘ Transport barriers deepen existing health inequalities

Digital exclusion

- ↘ Deprivation correlates with limited digital access and skills
- ↘ If transport information or booking is primarily digital, low-income households may be excluded
- ↘ Information asymmetry: those most able to pay can overcome complex journeys through taxis, while those least able cannot

↘ Mitigation

TPO2 explicitly targets improving access for people without car access. Community transport focus recognises affordability issues, with future option development to include cost implications.

The Case for Change recognises the need to reduce journey complexity (which increases reliance on expensive alternatives such as taxis).

↘ Further evidence needed

- ↘ Detailed cost analysis of transport barriers across deprivation deciles
- ↘ Audit of reimbursement scheme accessibility and uptake
- ↘ Modelling of how proposed interventions will impact lowest-income households

- Consideration of subsidised or free transport options for low-income households attending frequent appointments

Race and ethnicity

Potential impacts

Language and information barriers

- Ethnic minority populations may have limited English proficiency
- Timetables, signage, announcements predominantly in English
- Information barriers prevent journey planning and access to support

Cultural and religious considerations

- Prayer or worship facilities may be lacking at healthcare sites or transport hubs
- Gender-segregated or culturally appropriate care preferences may not be available at allocated or closest settings
- No data on whether transport planning considers cultural needs

Trust and safety

- Ethnic minority communities may face discrimination in transport settings
- Safety concerns using public transport in areas of racial tension
- No data on lived experience of ethnic minority patients

Health disparity intersection

- Some ethnic minority groups experience health disparities
- Transport barriers compound access to healthcare for conditions affecting specific groups, with potential for worsened health outcomes for ethnic minority communities

Mitigation

Partnership approach with NHS Boards provides opportunity for detailed Health Board Equality Impact Assessments.

Systematic mapping of deprivation patterns and car access has been undertaken.

Further evidence needed

- Survey response heavily skewed to white population: further data needed on how ethnic minority communities experience transport barriers
- Community engagement with ethnic minority communities in next phase
- Specific consultation on information accessibility (language, formats)

- Review of cultural and religious needs in healthcare transport planning as part of evidence base

Pregnancy, maternity, paternity, and family status

Potential impacts

Pregnancy and the postnatal period typically involve multiple planned NHS contacts, including regular midwife, GP and hospital appointments, so pregnant people are intensive users of health services over a relatively short period of time. Standard maternity pathways mean that most pregnant people will have around 8 to 10 face-to-face antenatal appointments, plus additional visits where there are clinical concerns, making reliable and affordable transport to health particularly important during pregnancy.

Pregnant women and transport barriers

- Pregnant women need regular antenatal appointments
- Physical discomfort on long journeys, with greater mobility changes and accessibility needs
- Limited specific data on pregnant women's experiences

Parents accompanying children

- Dual transport costs (self plus child or children)
- Need for child-friendly facilities at stops and on vehicles
- Mothers often primary carers, introducing a care coordination burden
- Cost barrier may prevent parents from attending healthcare with children

Single parents

- Often from lower-income households
- Limited flexibility for complex journey planning
- Higher likelihood of missing appointments

Mitigation

Carers' needs recognised in TPO5. Community transport can provide family-friendly options, demand-responsive transport could accommodate children.

Further evidence needed

- Specific consideration in future option development of family-friendly transport features
- Great engagement with maternity services and children's health services on transport barriers

SECTION 4: Cross-cutting equality issues

Intersectionality

Many individuals experience multiple intersecting inequalities. Examples identified in the evidence base include:

Case 1: Older, disabled, rural, low-income woman

- Lives in remote Borders with no car, partner recently passed away
- Has diabetes and mobility impairment
- GP relocated, nearest is 20 minutes' walk (cannot manage)
- Hospital in Melrose 45 minutes by public transport (two buses, one interchange)
- Lives on fixed pension income, cannot afford taxi frequently

↘ Cumulative impact: reduced access to primary care, complex barrier to hospital care, reliance on irregular community transport, financial vulnerability, social isolation, worsening health outcomes

Case 2: Young, low-income, non-driver carer living in semi-rural area

- Provides unpaid care to ageing parent
- Works part-time, attending GP with parent requires juggling multiple responsibilities
- No flexibility in appointment timing
- Cost of transport adds to financial precarity

↘ Cumulative impact: Time poverty, financial stress, risk of missing carer's own health appointments, burnout

Case 3: Disabled person of ethnic minority background living in deprived urban area

- Limited English proficiency, digital access limited
- Chronic health condition requiring frequent hospital appointments
- Wheelchair user, accessibility barriers on buses (long walk to stop, barriers, inaccessible interchange)
- Experiences racism on public transport, safety concerns

↘ Cumulative impact: Multiple information barriers, accessibility barriers, safety concerns, cost burden, health deterioration

Positive equality duties

Beyond avoiding negative impacts, public bodies have duty to advance equality and foster good relations. Opportunities in the Transport to Health Strategy include:

1. Advancing equality of opportunity: improving transport to healthcare directly enables more equal access to health services. Reducing transport barriers particularly benefits disabled people, older adults, and low-income households. This could actively improve health outcomes for disadvantaged groups.

2. Reducing transport poverty: targeted improvements to community transport, demand-responsive services could directly address transport poverty, while affordable or free transport options could support low-income households.
3. Fostering good relations: cross-sector partnership (transport, health, communities sectors) builds shared understanding, while engagement with disabled people's organisations and community groups strengthens relationships. This can improve how community transport providers recognised and valued.

SECTION 5: Evidence gaps and limitations of assessment

Consultation and engagement gaps

There is no specific consultation with ethnic minority communities, and limited engagement with LGBTQ+ health services or communities. There is also limited engagement with mental health users and consultation could be more accessible to people with communication support needs (deaf, British Sign Language users, etc.).

The survey evidence snapshot from October to November 2025 may not capture seasonal variations or recent service changes. As this is an assessment at the Case for Change stage, the impacts will need reassessment at option development and detailed appraisal stages.

Population projections to 2032 are identified, but not systematically linked to equality impacts.

SECTION 6: Further work for strategy development phase

Further work for the next phases of the Transport to Health Strategy development should consider the following points:

1. Expand evidence base on underrepresented groups:
    a. Ethnic minority communities
    b. LGBTQ+ health services and communities
    c. Mental health services and service users
    d. Women's health services (maternity, reproductive health, women's mental health)
2. Accessibility audit and user-led design
    a. Systematic audit of accessibility of current transport network (bus, rail, community transport, taxi)
    b. User-led co-design process involving disabled people
    c. Consider accessibility standards (e.g., British Standard for accessible urban design)
3. Carer and unpaid care considerations
    a. Specific work with carer organisations to understand transport needs

   b. Consider subsidised or free carer transport
   c. Review reimbursement scheme accessibility

4. Cost-benefit analysis with equity focus
   a. Standard cost-benefit analysis plus equity considerations
   b. Who benefits financially from interventions?
   c. Who bears the costs?
   d. Consider progressive pricing (those with more ability to pay subsidise those with less)

5. Information accessibility and multi-lingual support
   a. Audit current transport information accessibility (formats, languages, digital/non-digital)
   b. Ensure information accessible to people with visual, hearing, cognitive impairments
   c. Provide non-digital routes

6. Safety and security
   a. Consult with women's safety groups, ethnic minority communities on safety concerns
   b. Review of CCTV, lighting, staffing at transport hubs
   c. Training for transport workers on equalities and anti-discrimination

7. Appointment scheduling and transport alignment
   a. Work with NHS Boards to identify how appointment scheduling can be aligned with transport availability
   b. Consider flexible, remote consultations where appropriate to reduce unnecessary travel

8. Community transport integration and funding
   a. Systematic review of community transport capacity and sustainability
   b. Work with providers to understand funding gaps and barriers to expansion
   c. Consider how statutory funding can support community transport expansion
   d. Ensure community transport is visible and accessible to people who need it

Next steps

This Case for Change establishes a robust, region-wide evidence base for Transport to Health across the SEStran area. The Problems, Opportunities, Issues and Constraints identified in this report will inform the next stage of work to develop a Regional Transport to Health Strategy.

The next phase will focus on:

- Refining and agreeing the Transport Planning Objectives with partners
- Developing a longlist of potential interventions aligned to these objectives
- Undertaking initial sifting to identify feasible and impactful options
- Considering distributional and equality impacts alongside deliverability and value for money

This work will be taken forward collaboratively with NHS Boards, local authorities, transport operators, community transport providers and third-sector partners. Ongoing engagement and further qualitative insight, including planned focus groups and pop-up engagement, will continue to inform the development and refinement of options.

APPENDIX A:

Survey Response Overview

Appendix A: Public survey response overview

SEStran Transport to Health Case for Change: Public consultation

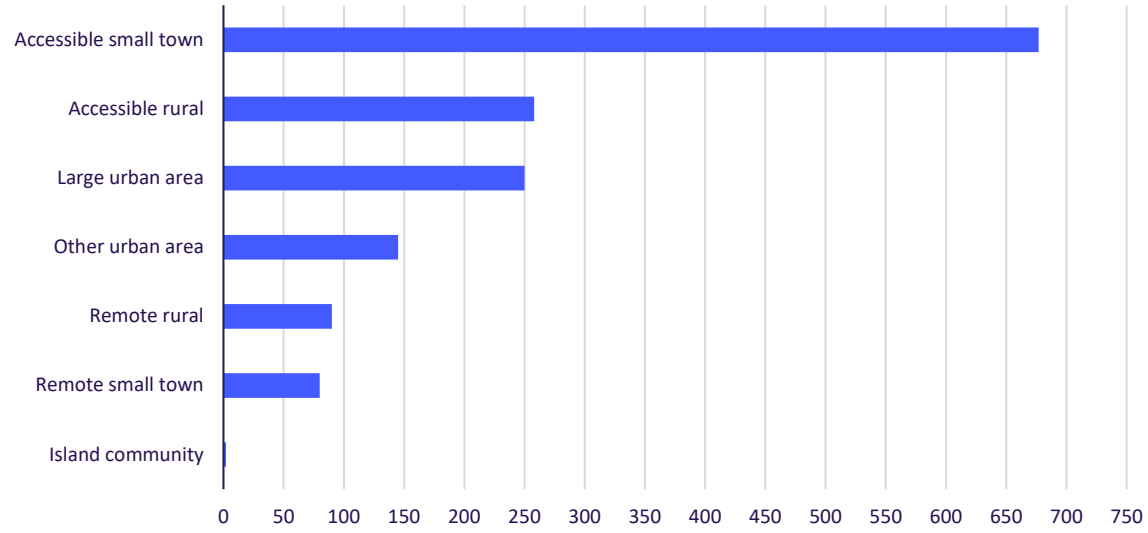
The survey analysis below relates to the public consultation phase of the SEStran Transport to Health Case for Change development. The consultation was delivered through a public survey, supported by a paid advertising campaign that ran for three weeks. The survey was open for six weeks in total. It was primarily accessible online, with paper copies available on request.

Q1 What are the first 4-5-digits of your postcode? (e.g., EH8 1, TD15 2)

Responses: 1346

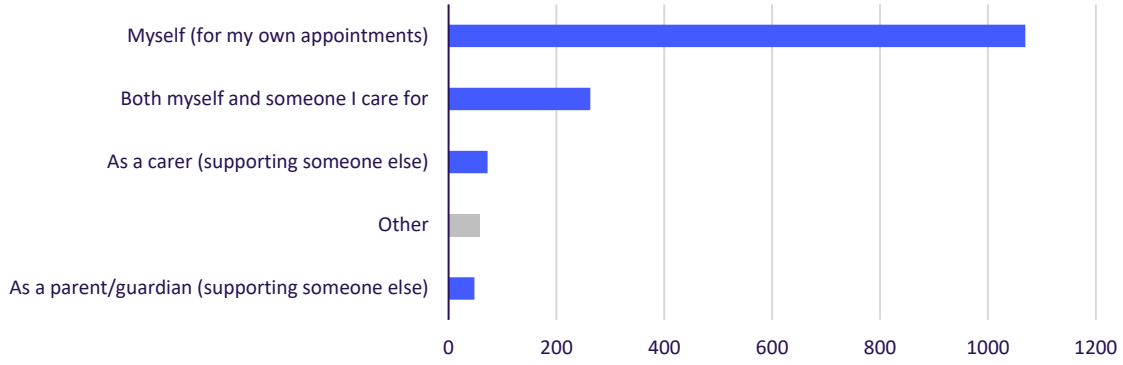
Q2 Which do you feel best describes where you live?

Responses: 1502



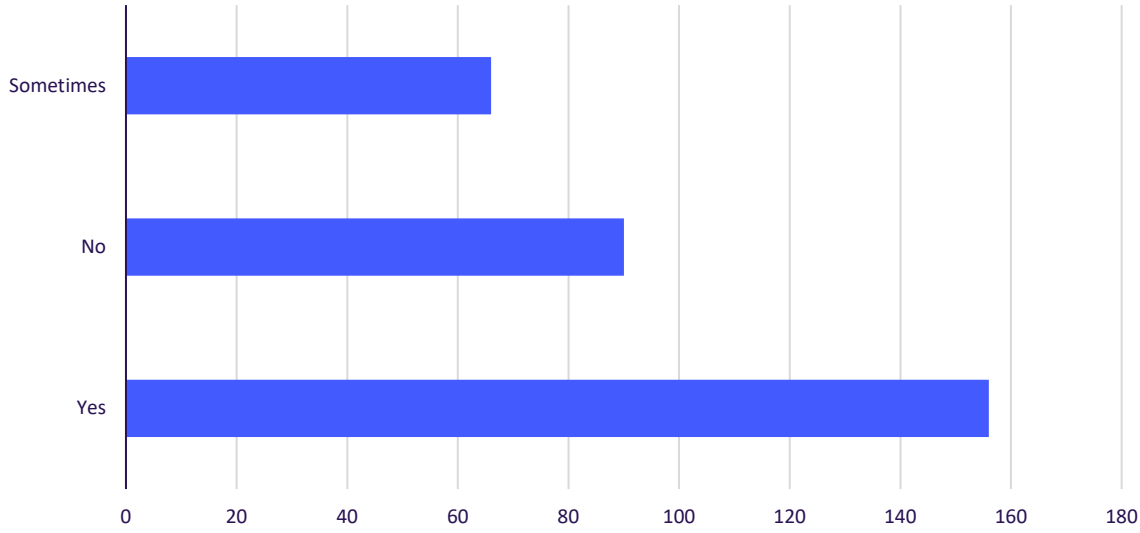
Q3 Who are you usually travelling for when attending healthcare appointments?

Responses: 1510



Q4 If you are a carer, does transport affect your ability to support or attend appointments?

Responses: 312



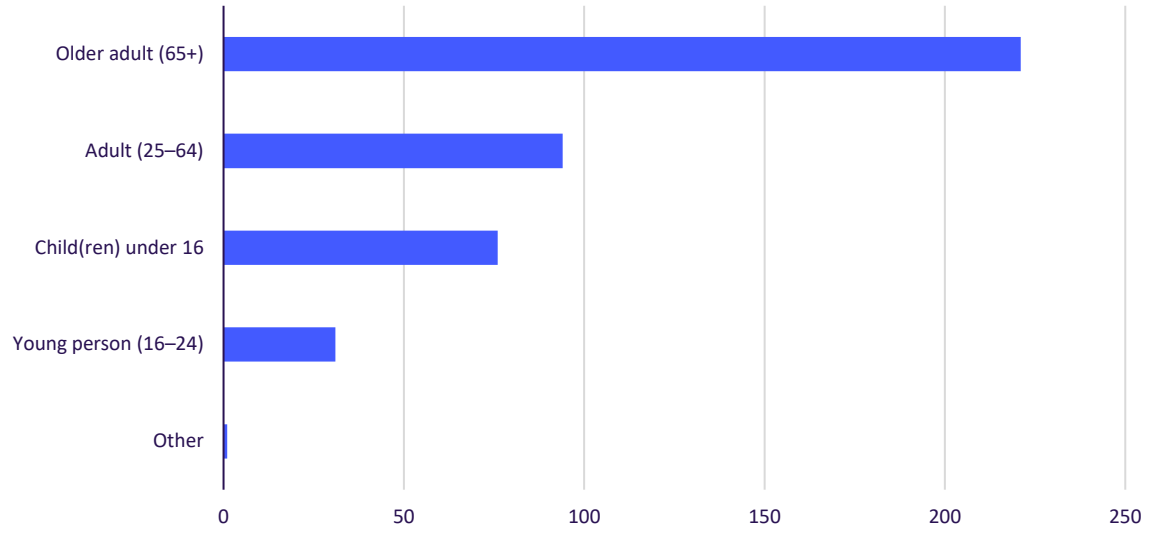
Q5 Please briefly describe any challenges you face as a carer when arranging or using transport for healthcare appointments.

Responses: 203

Random sample of responses
Difficult to get parked, patient transport won't come to our home (single lane country road). Can't get to public transport stops as they are over 2 miles away.
Child has severe motion sickness; long distances force us to disembark and walk for hours.
When the person I care for can't drive, it takes all day to go to hospital and back home
There is no longer a bus service so my mother cannot travel on her own. I therefore have to take time off work to drive her. There is no local minor injuries or accident emergency, so we also have a long journey into Edinburgh for that.
I don't drive so rely on public transport and living at the opposite side of the city to the hospital takes almost 1.5 hours each way.

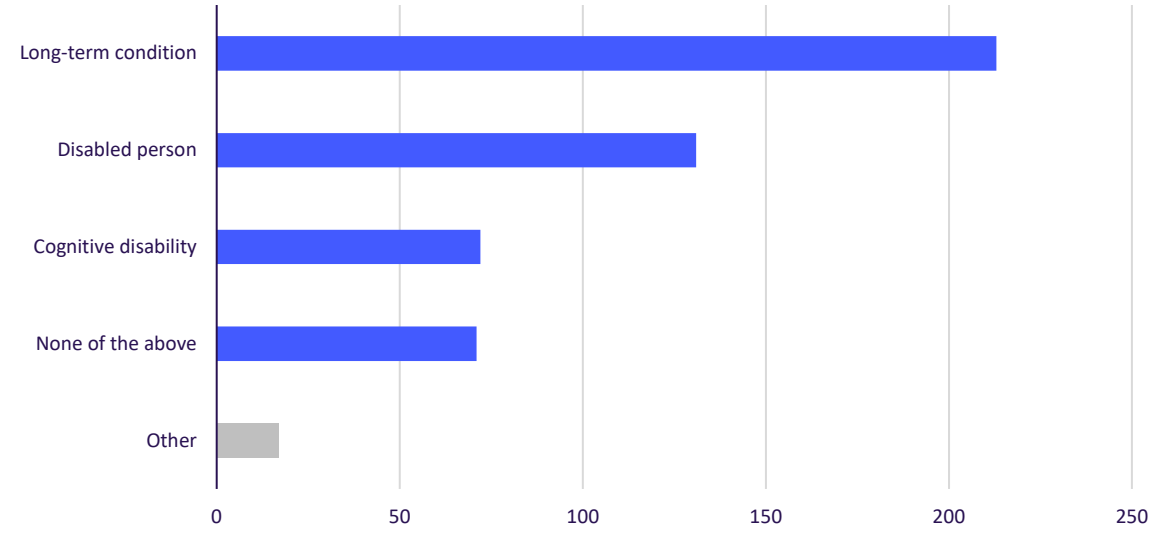
Q6 Who do you usually support when travelling to healthcare appointments? (Tick all that apply)

Responses: 423



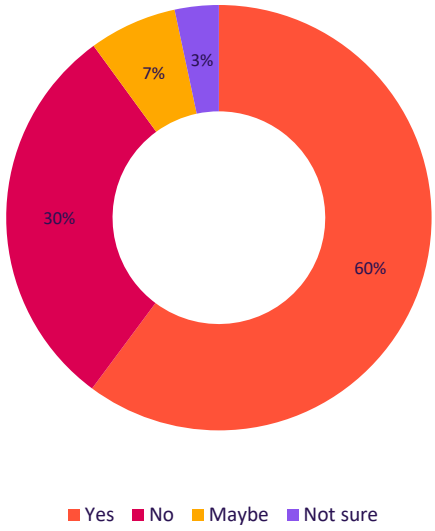
Q7 Does the person you support fall into any of the below categories (Tick all that apply)

Responses: 504



Q8 Do the people you support face any additional transport barriers? (e.g. mobility, accessibility, cost, confidence, safety, communication or language barriers)

Responses: 359



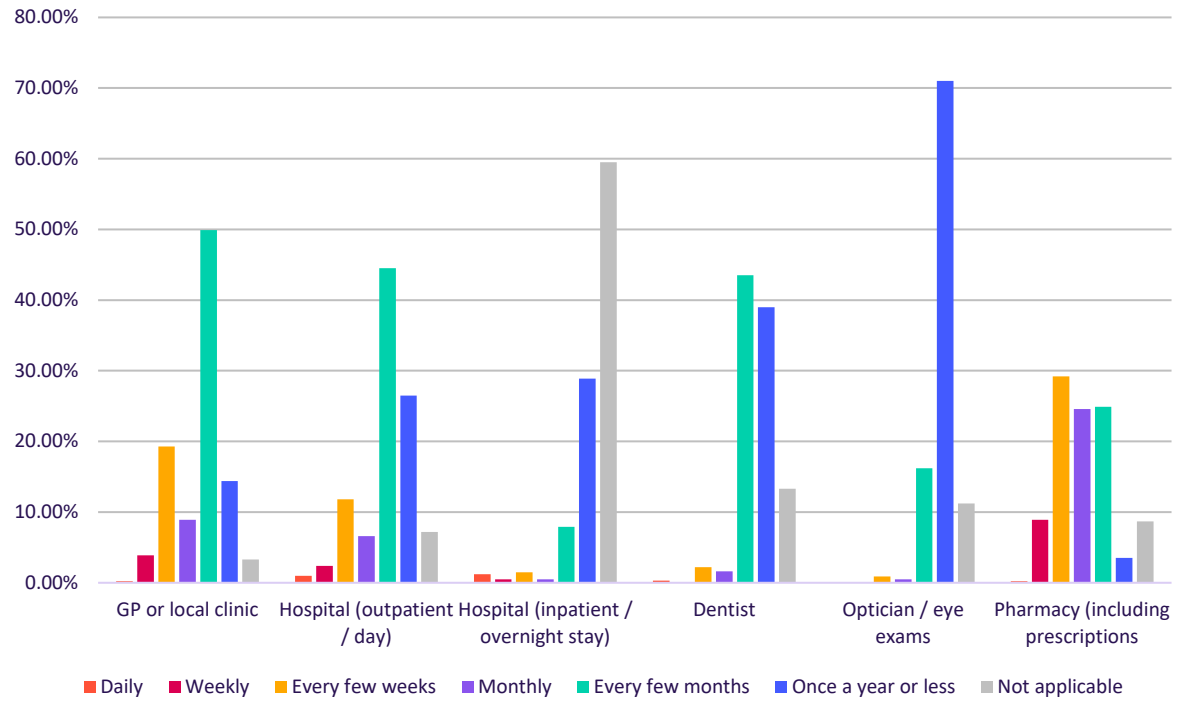
Q9 Do the people you support face any additional transport barriers? (e.g. mobility, accessibility, cost, confidence, safety, communication or language barriers), Please describe briefly

Responses: 203

Random sample of responses
Lack confidence to make journeys by bus due to visual impact of health condition and challenges in communicating and dealing with Interchange between services
Person uses Electric Wheelchair due to poor mobility. Also has difficulties communicating and understanding
My husband and I both have mobility issues requiring expensive taxi fares which living on benefits we can't afford
Frail, elderly sometimes confused
not be able to travel with the local bus provider because if not being allowed folding mobility scooter in bus even when folded up

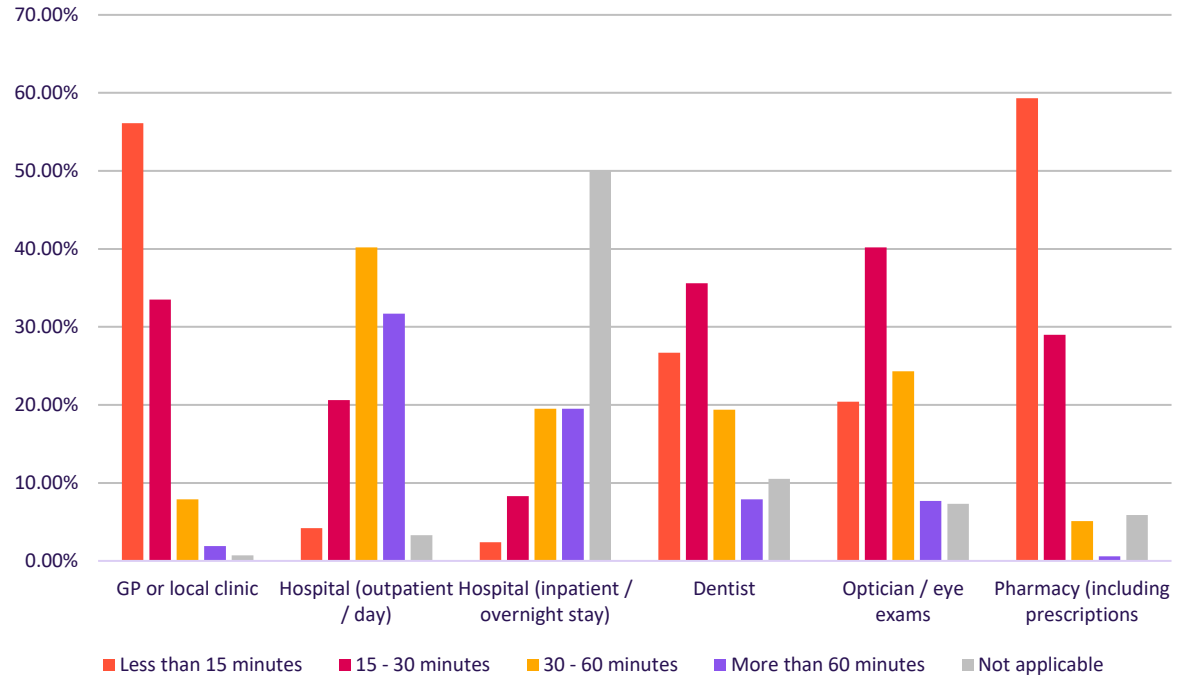
Q10 In the past 12 months, how often have you or someone you support travelled for the following types of healthcare?

Responses: 1447



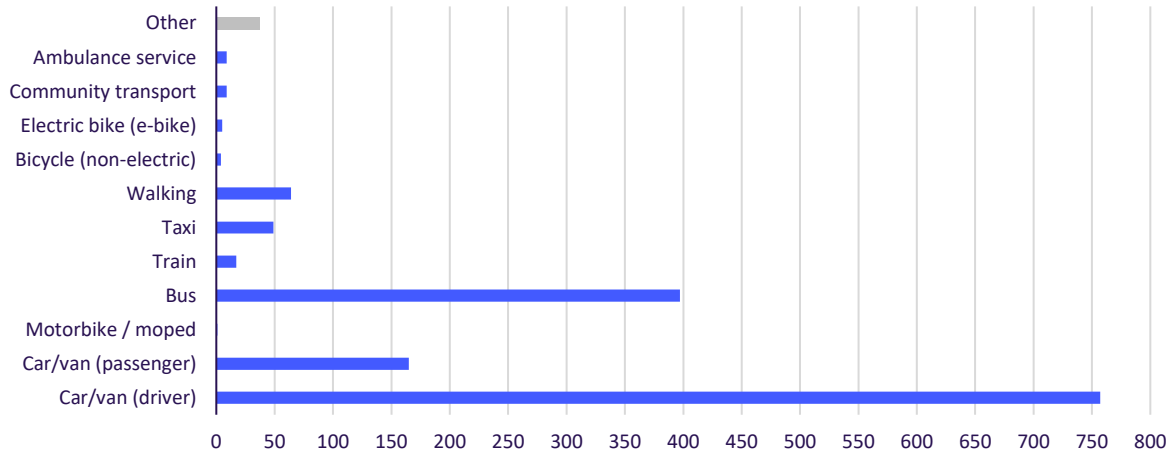
Q11 How long is your usual journey to a healthcare appointment (one way)?

Responses: 1470



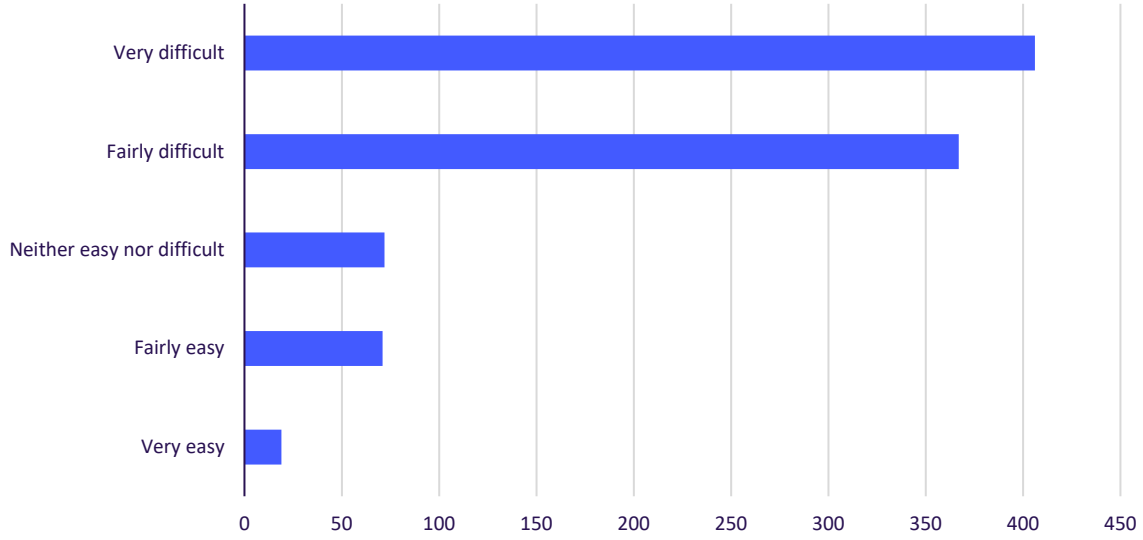
Q12 What is your main mode of transport you usually use to travel to healthcare appointments?

Responses: 1514



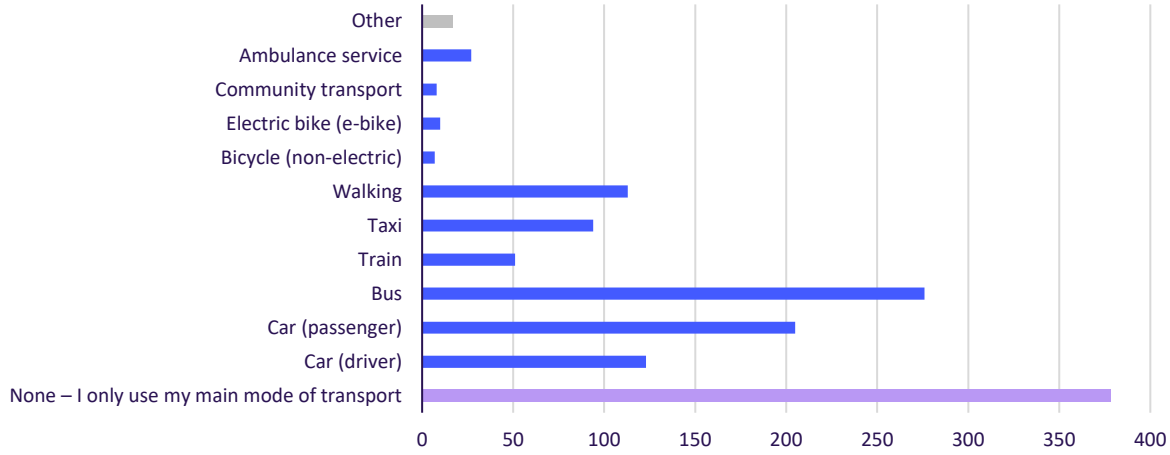
Q13 How easy would it be to attend without using a car/van?

Responses: 935



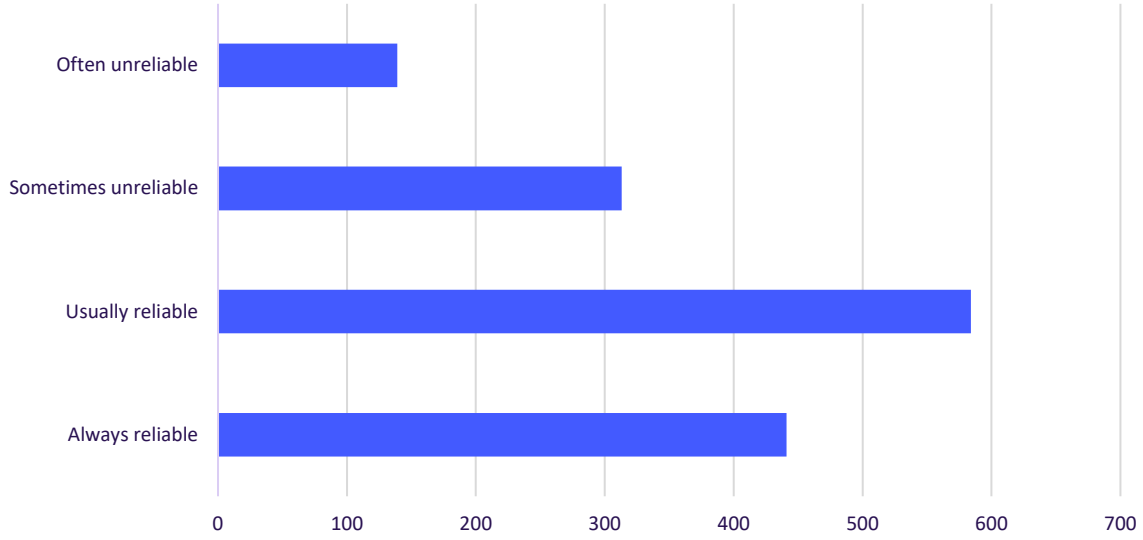
Q14 Do you rely on any other types of transport to reach healthcare appointments - for example, when your main option isn't available, or for certain trips?

Responses: 1309



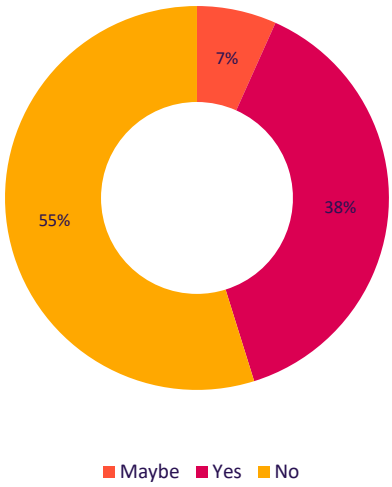
Q15 How reliable do you find the transport you usually use for healthcare?

Responses: 1477



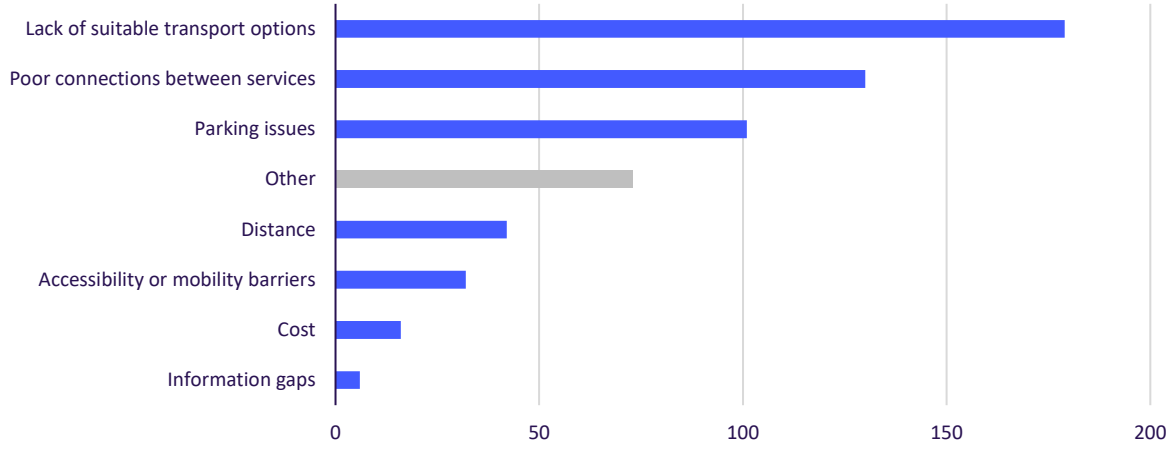
Q16 Have you ever missed or delayed a healthcare appointment due to transport issues?

Responses: 1505



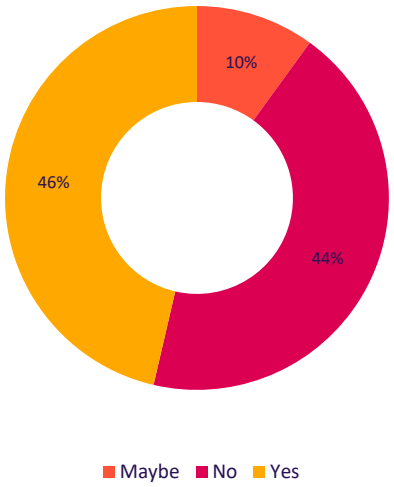
Q17 If yes, what was the main reason? Tick any that apply:

Responses: 579



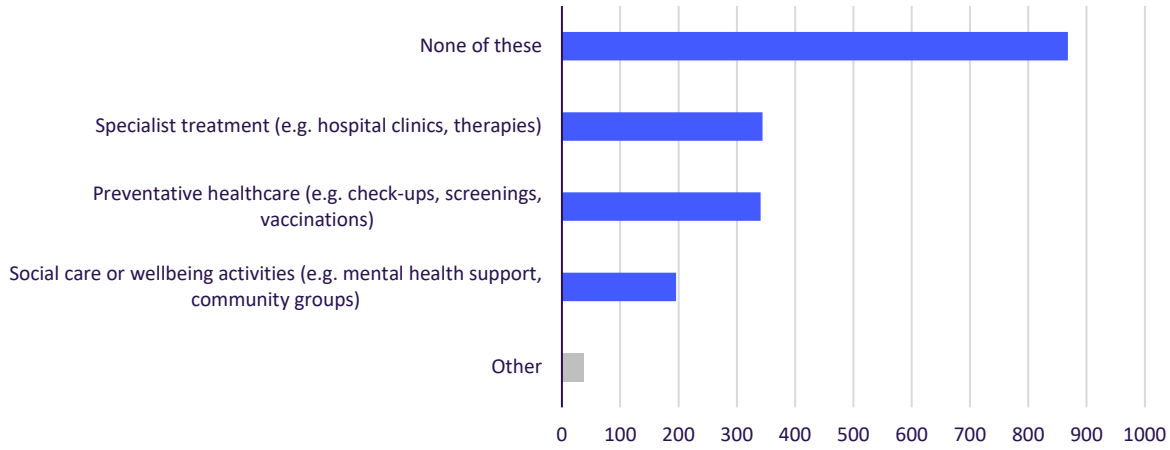
Q18 Have transport issues ever affected your health or wellbeing?

Responses: 1499



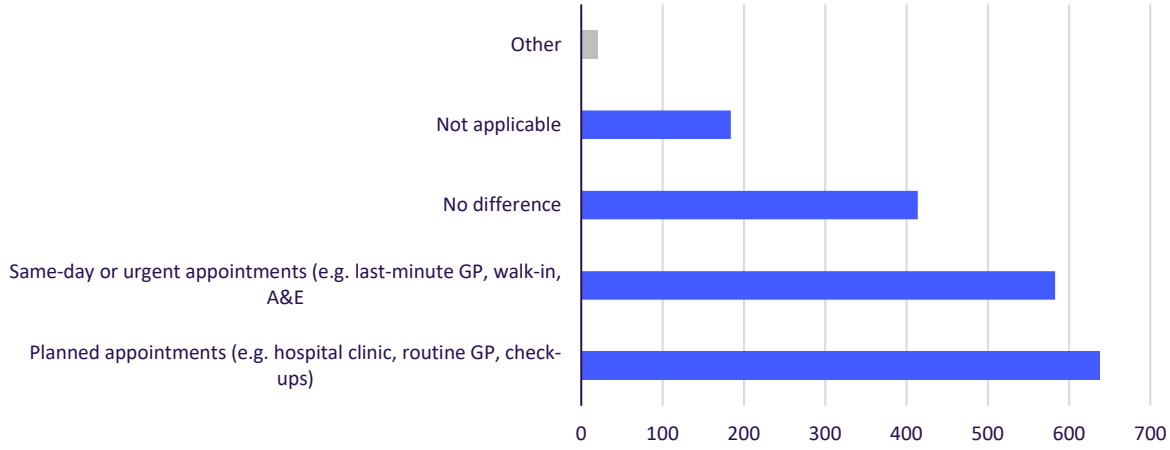
Q19 Have transport difficulties ever prevented you from accessing any of the following? (Tick all that apply)

Responses: 1786



Q20 Do transport challenges affect you differently depending on the type of appointment? (Tick all that apply)

Responses: 1839



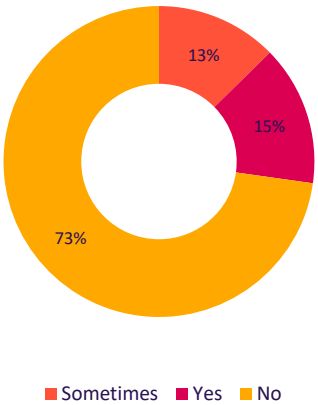
Q21 Please briefly tell us more about any differences or challenges you experience when travelling to different types of appointments. (Optional)

Responses: 984

Random sample of responses
require to travel to city (Western Hosp) so use car then train then bus and walk then reverse on return journey.
Given appointment to attend Borders General Hospital which is 23 miles each way Unable to attend as Transport informed booking stop @ midday no other advice given
With unplanned and more urgent appointments, especially at weekends or evenings, infrequent bus service and bus journey can mean that the only option is an expensive taxi
Issues with parking for hospital appointments, GP are fine, dentist within walking distance but the hospital is a nightmare & due to this have been just about late for appointment
Out of hours appointments not easy to get to without a car

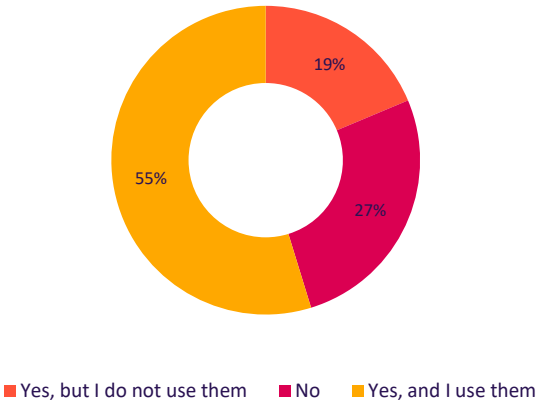
Q22 Do transport costs affect your decision or ability to attend healthcare?

Responses: 1487



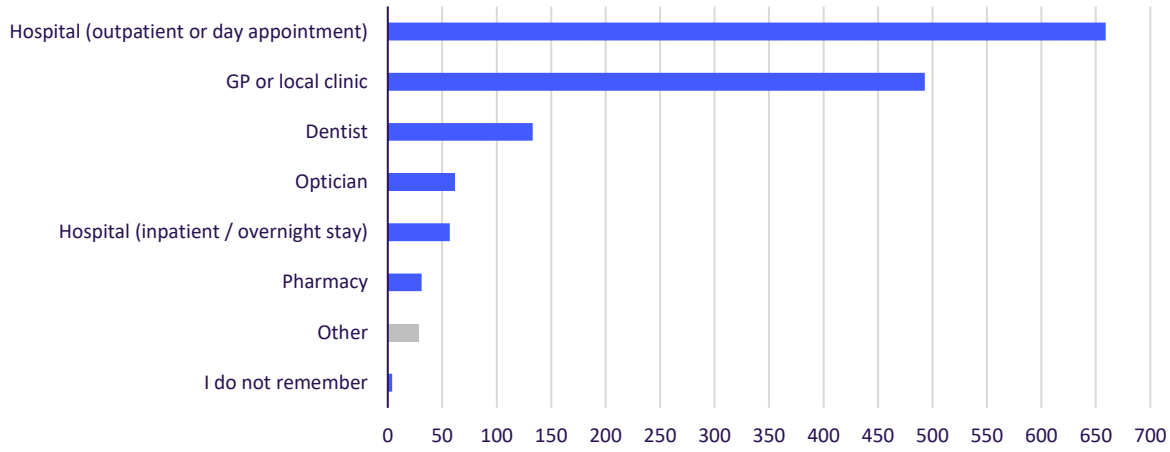
Q23 Are you eligible for and do you use a free bus pass or other travel concessions?

Responses: 1484



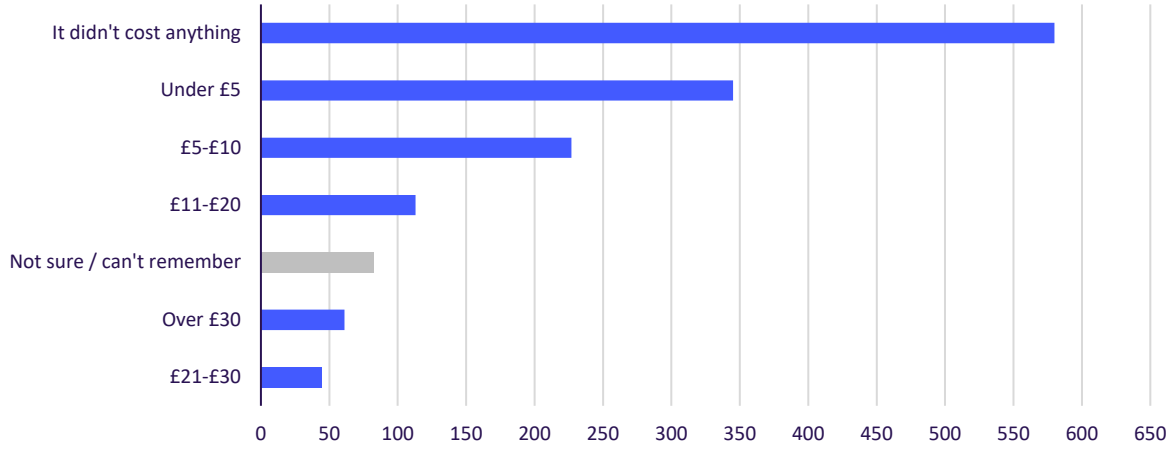
Q24 Thinking about your most recent healthcare appointment, what type of appointment was it?

Responses: 1466



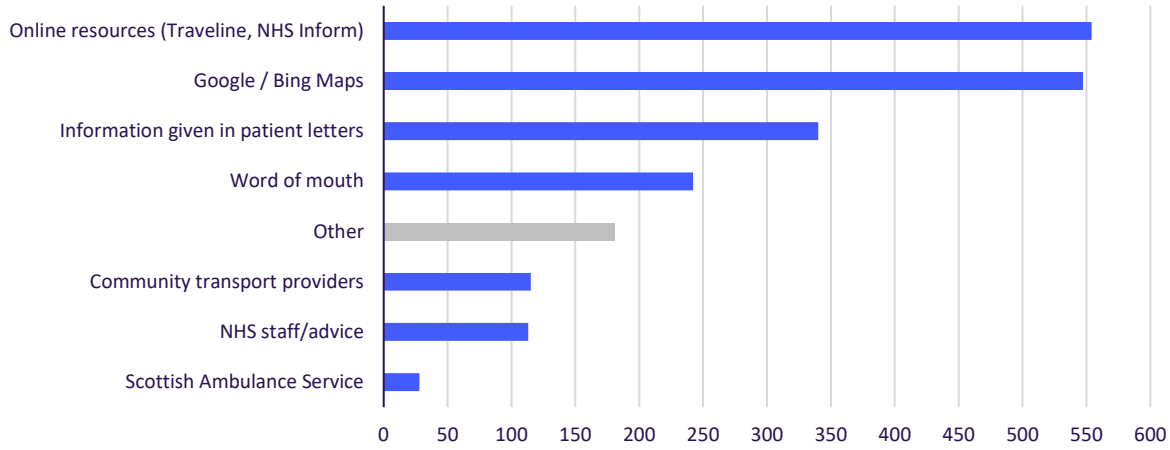
Q25 Roughly, how much did your return journey cost for this appointment?

Responses: 1452



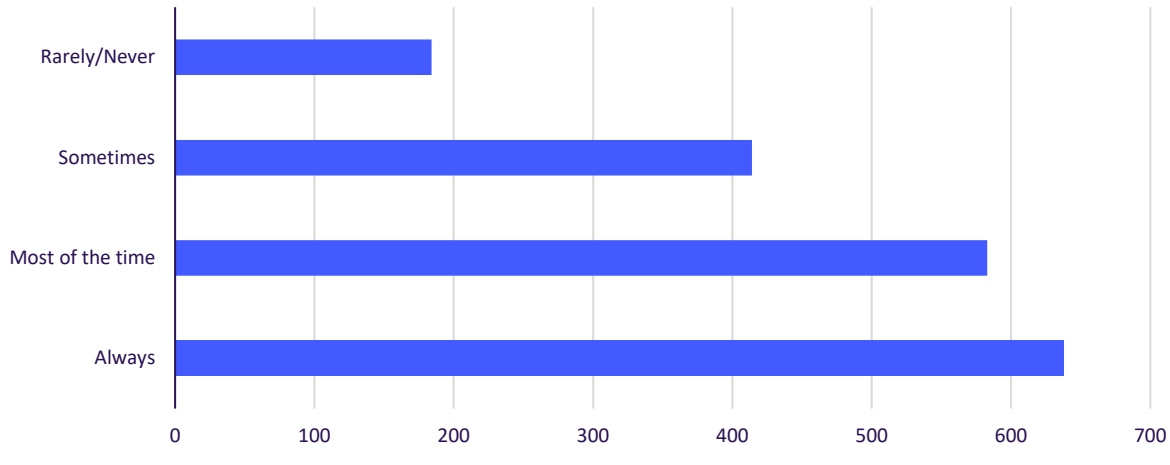
Q26 Where do you usually get information on travel options to healthcare? (tick all that apply)

Responses: 2120



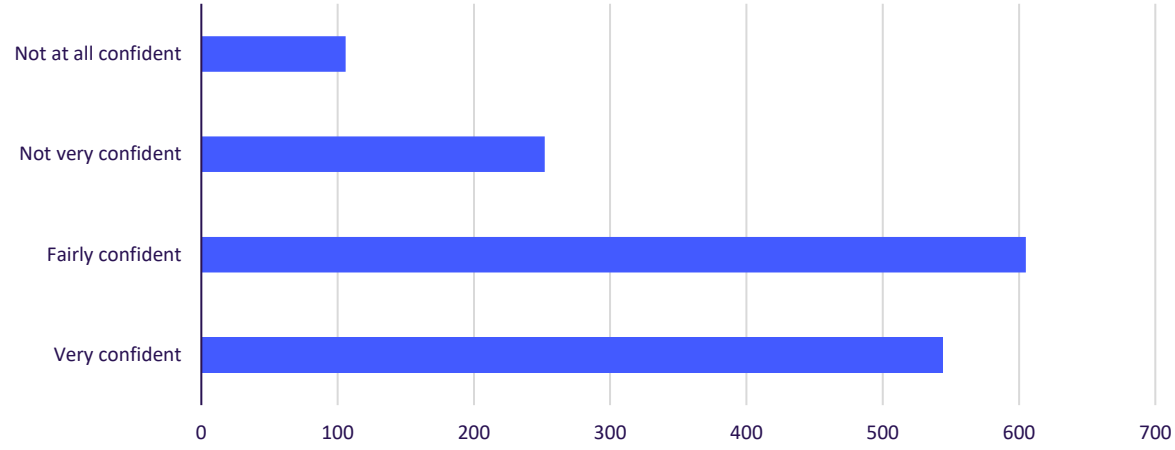
Q27 The information I need about travel (routes, times, reimbursement, carer support) is easy to find and understand.

Responses: 1819



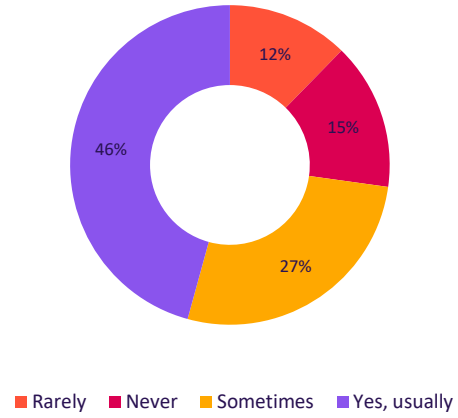
Q28 How confident are you using online/digital tools to find travel information or book transport?

Responses: 1507



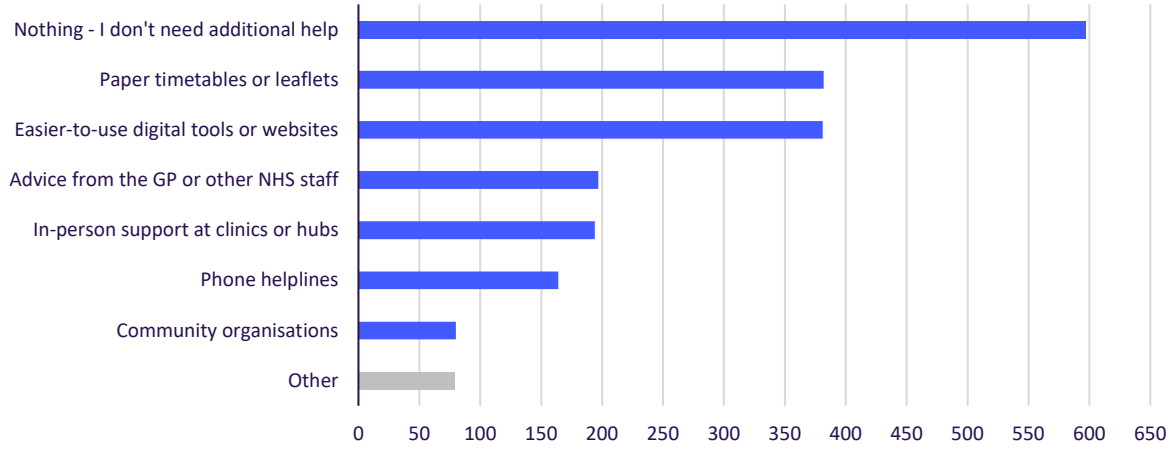
Q29 Do you usually use online or digital tools to find travel information or book transport?

Responses: 1511



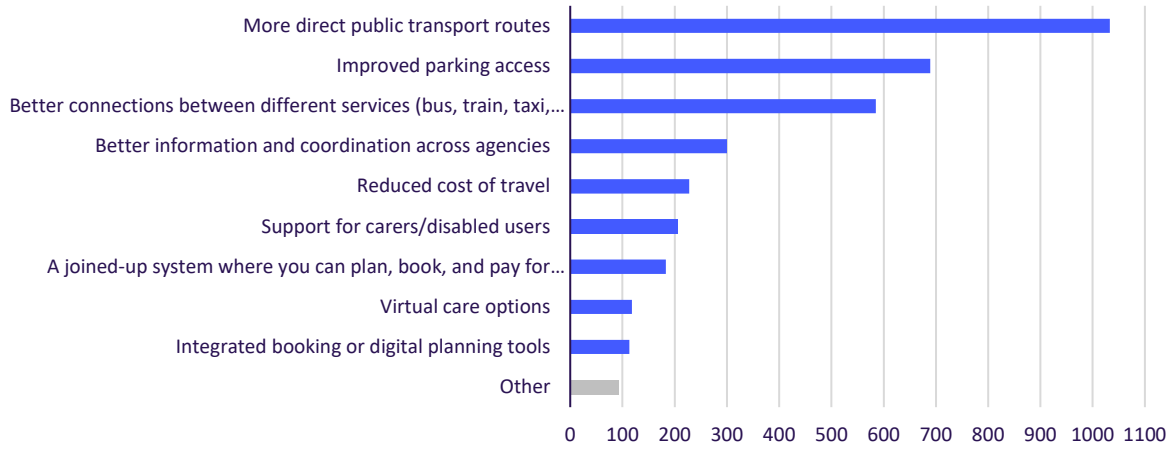
Q30 What would make it easier for you to find travel information or book transport?

Responses: 2074



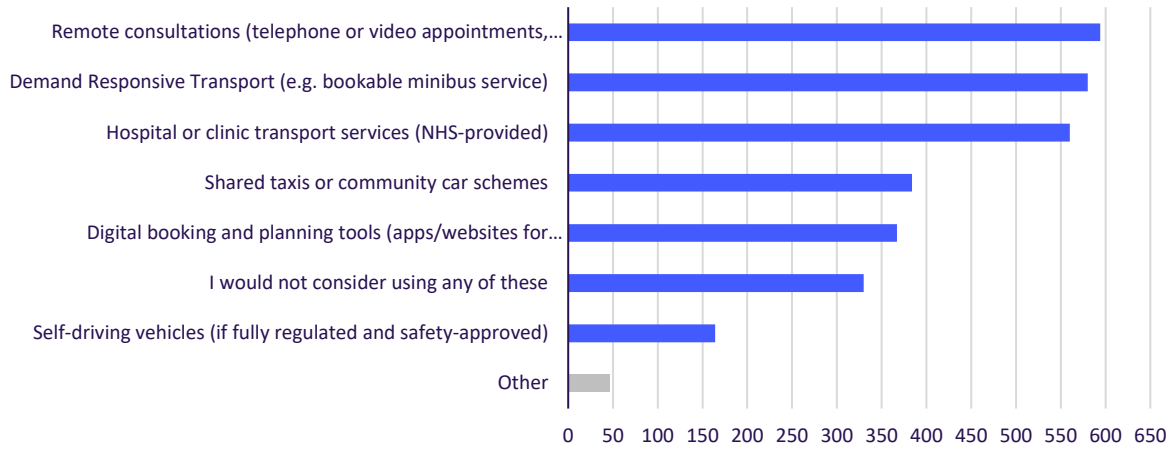
Q31 What would be the top 3 things that would most help you get to healthcare appointments?

Responses: 3548



Q32 Would you consider using any of the following to help you access healthcare, if they were available in your area? (Tick all that apply)

Responses: 3025



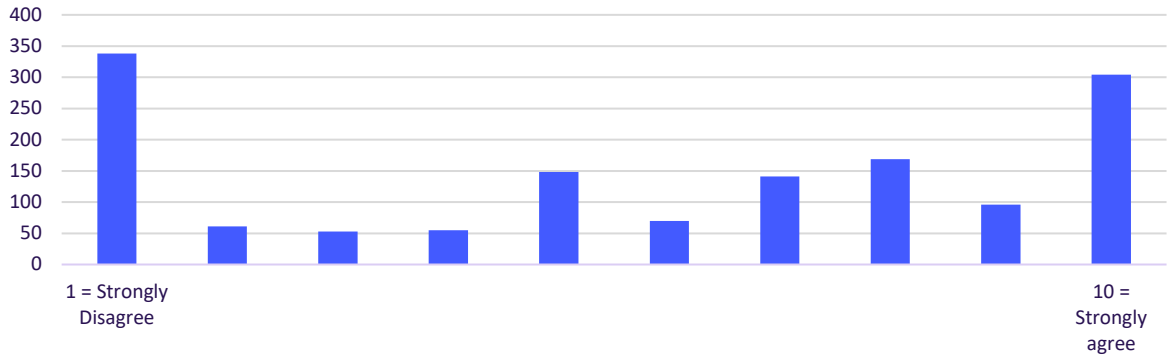
Q33 Are there particular services or locations where transport barriers are worst?

Responses: 1016

Random sample of responses
All of them because there is no public transport and none of these services are in my immediate community, closest is 8 miles away
Victoria Hospital Kirkcaldy. Parking situation horrendous
Victoria hospital Kirkcaldy's. Dentist is now in St Andrews 45 mins drive (plus parking) as I cannot get local … this is very costly in fuel etc and time off work
Royal Infirmary of Edinburgh/RHCYP/DCN is hard to access from any area of Midlothian via public transport with very limited direct links I also cannot reach the community hospital via public transport
Edinburgh Western Infirmary has inadequate parking and barriers always breaking. Dental hospital is too difficult to get to from train station if walking is a problem. I paid £10 in a taxi

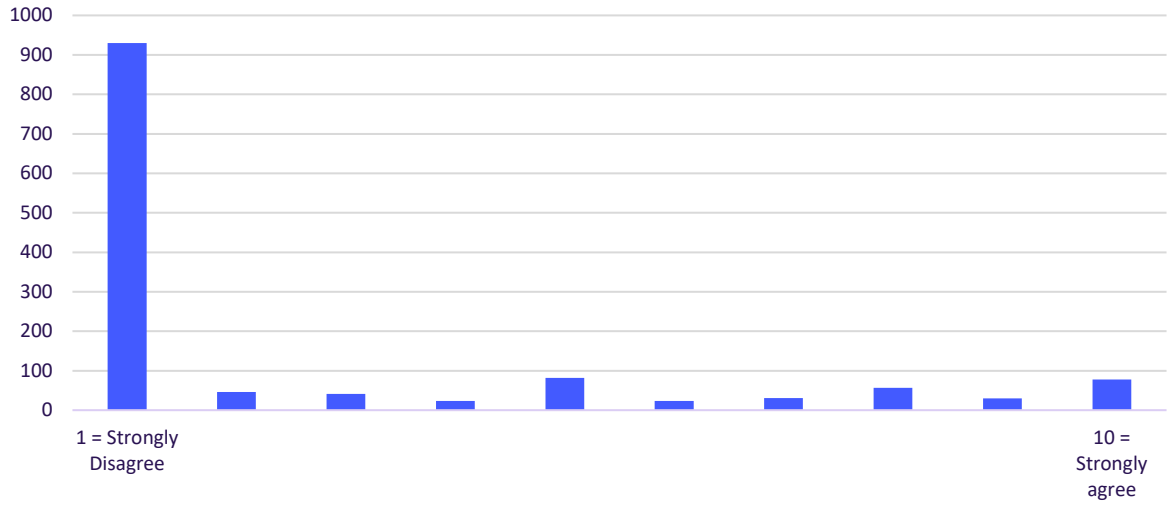
Q34 Physical disability or mobility issues make travel to healthcare more difficult for me or someone I support.

Responses: 1435



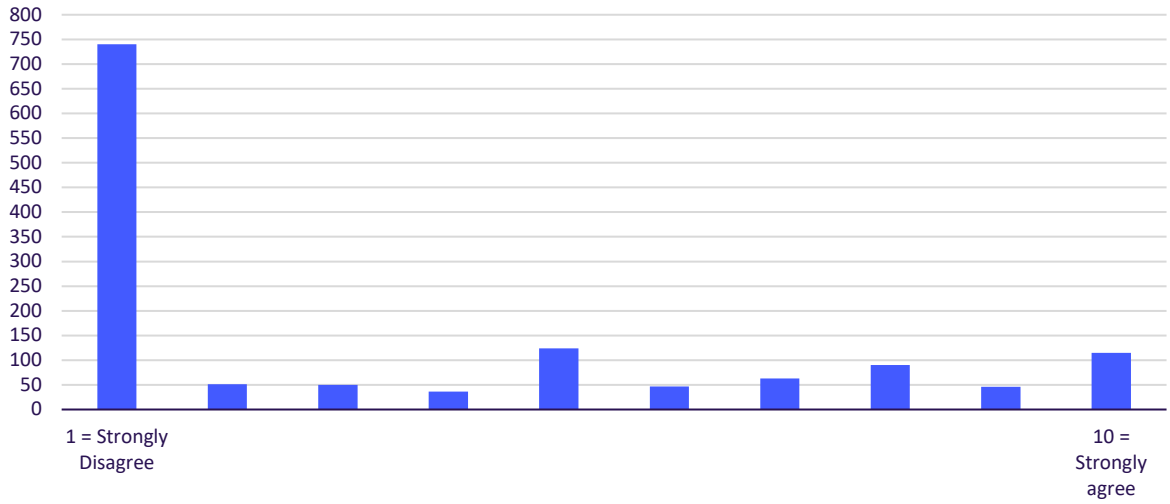
Q35 A learning disability makes travel to healthcare more difficult for me or someone I support.

Responses: 1341



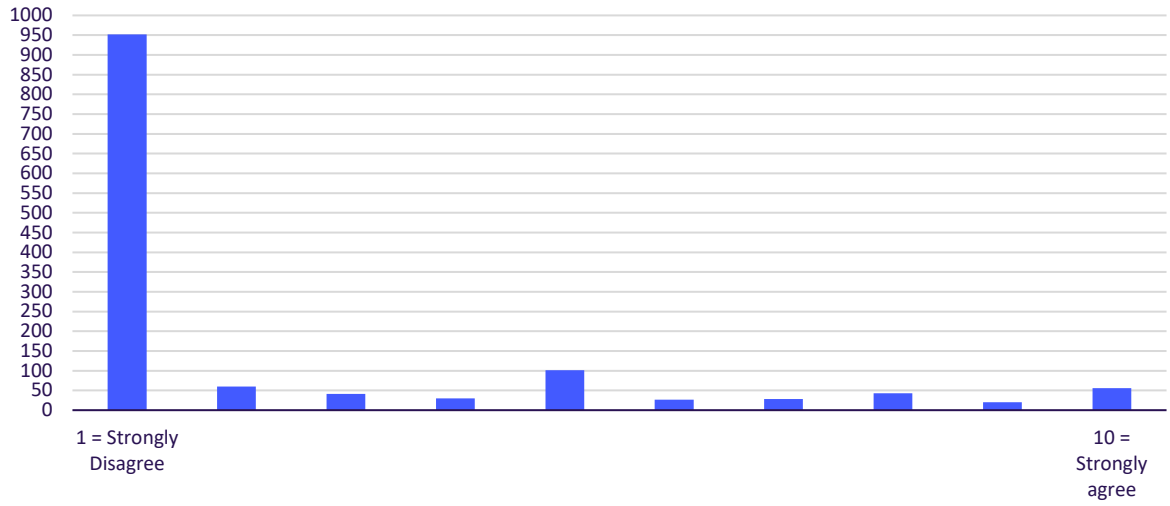
Q36 Mental health conditions make travel to healthcare more difficult for me or someone I support.

Responses: 1362



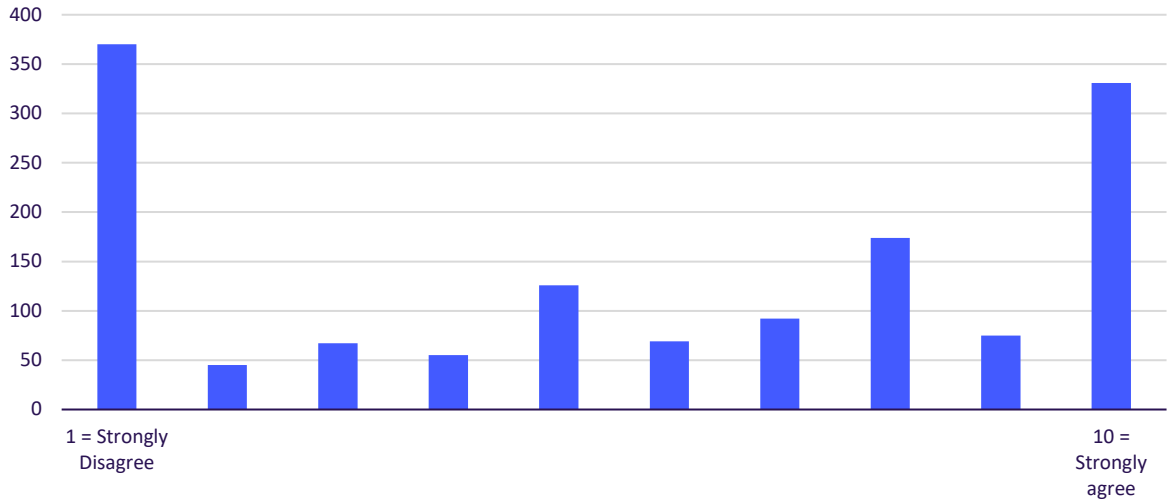
Q37 Communication or language barriers make travel to healthcare more difficult for me or someone I support.

Responses: 1358



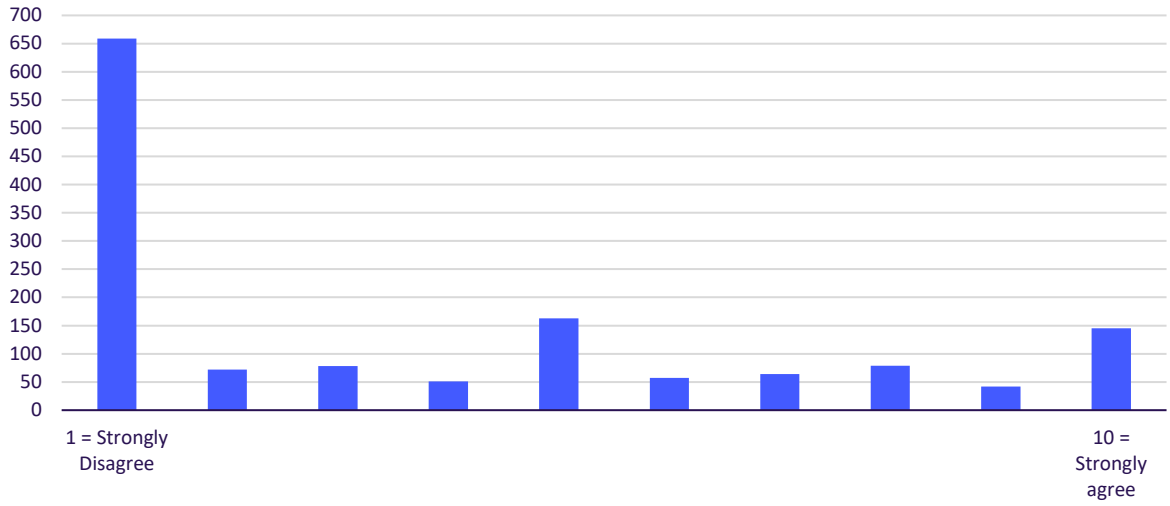
Q38 Rural isolation or lack of nearby services make travel to healthcare more difficult for me or someone I support.

Responses: 1404



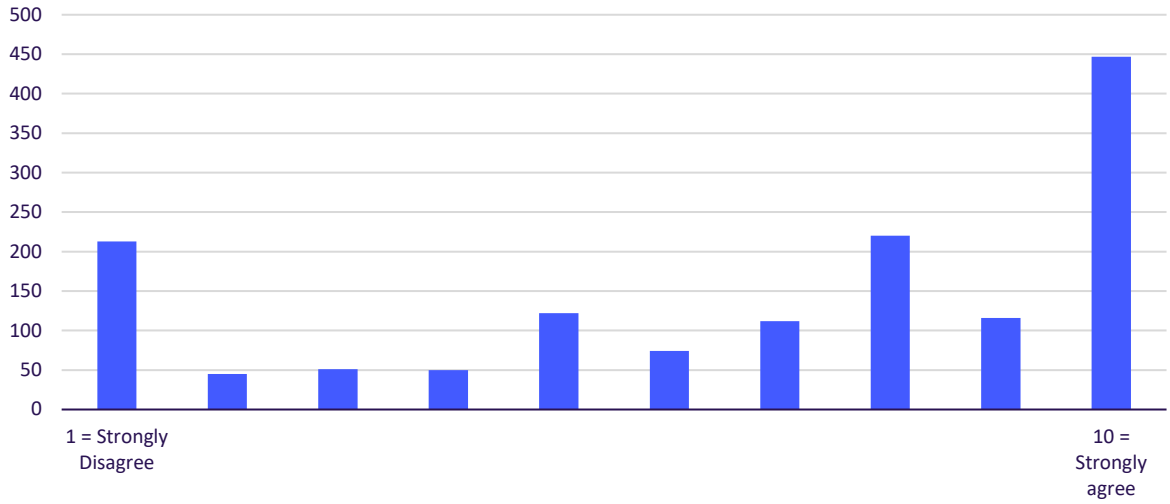
Q39 The cost of travel makes it more difficult for me or someone I support. Rural isolation or lack of nearby services make travel to healthcare more difficult for me or someone I support.

Responses: 1410



Q40 A lack of reliable or available transport options makes travel more difficult for me or someone I support.

Responses: 1450



Q41 Are there any other factors that make travel to healthcare more difficult for you or someone you support? (optional)

Responses: 479

Random sample of responses
I am quite happy to get the train and walk a mile to an appointment in Edinburgh (or Livingston); but need transport to come back home after an operation.
I am mostly unwell and if I had to get a bus I first have to walk half an hour to the main bus route, I cannot do that
One bus an hour from village to GP surgery. Appointment times rarely work out for bus there and bus back. No streetlights or pavements so walking (50mins each way) not feasible.

Random sample of responses
Im about 2 miles from the hospital. A taxi is under a tenner, around £8, I think. The bus takes exactly an hour from the hospital to bus stop near my house. It does the science route through the estates
Just bus times

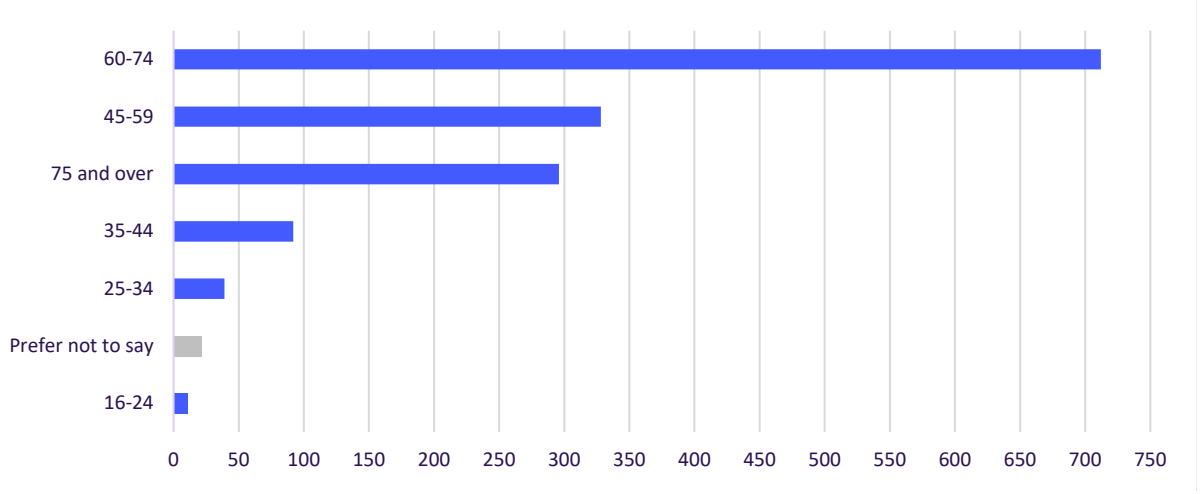
Q42 Do you have any other comments or suggestions on how transport to healthcare could be improved in your area? (optional)

Responses: 534

Random sample of responses
No would be same as previous comment more or less. Better access on buses for disabled/new parents with prams, like maybe create buses with more than one wheelchair/pram space.
Better public transport connections between the towns and villages in Midlothian.
Temporary disabled badges for people with short/ medium length disability i.e. broken legs
Availability of public transport in East Lothian regresses every year and given the ever-increasing population of East Lothian, the public transport system for medical care is simply not fit for purpose.
More transport links. Reduce rail fares, make public transport safer for women and vulnerable to travel on. Special buses for hospitals running along coastal routes

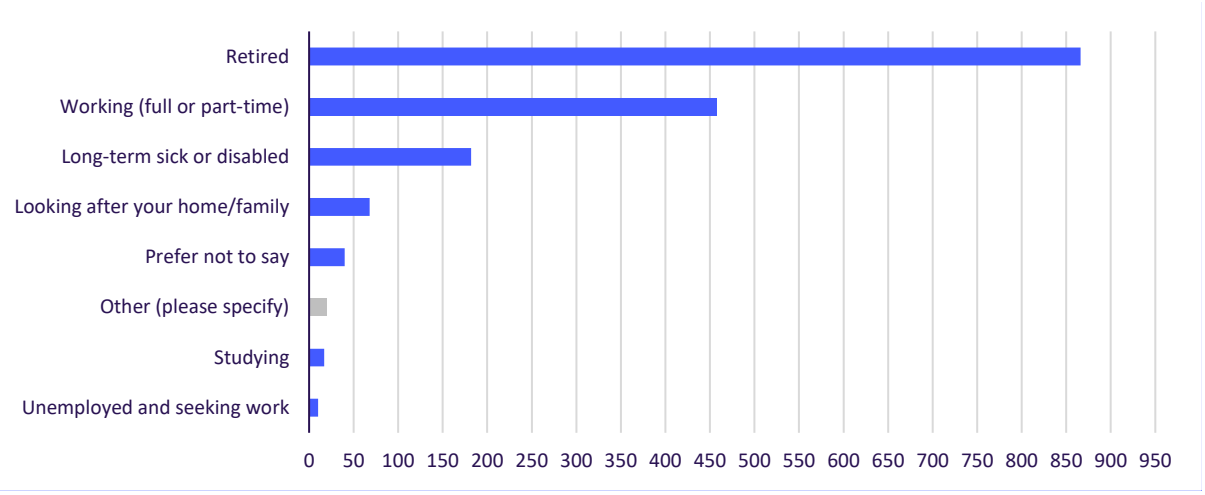
Q43 Please select your age group

Responses: 1500



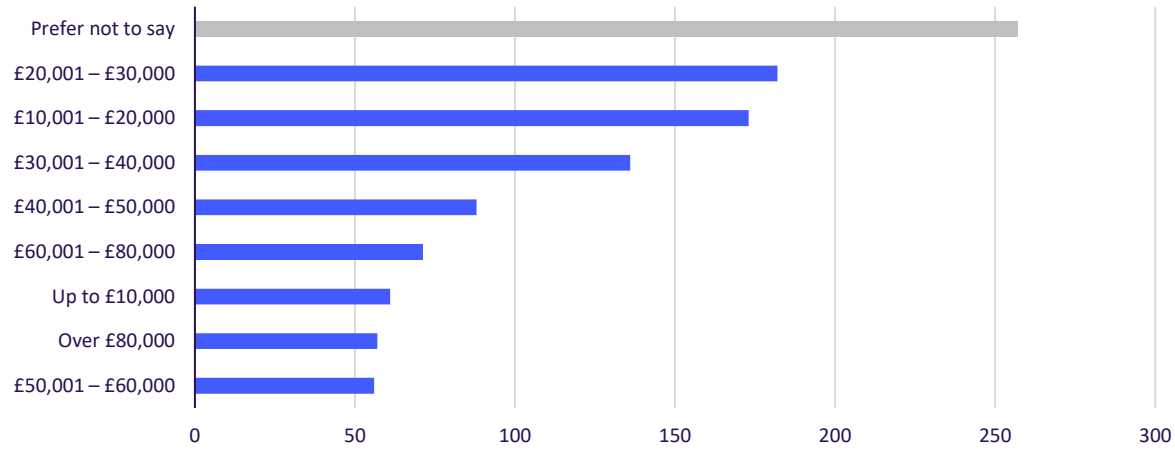
Q44 What is your current situation? (Tick all that apply)

Responses: 1661



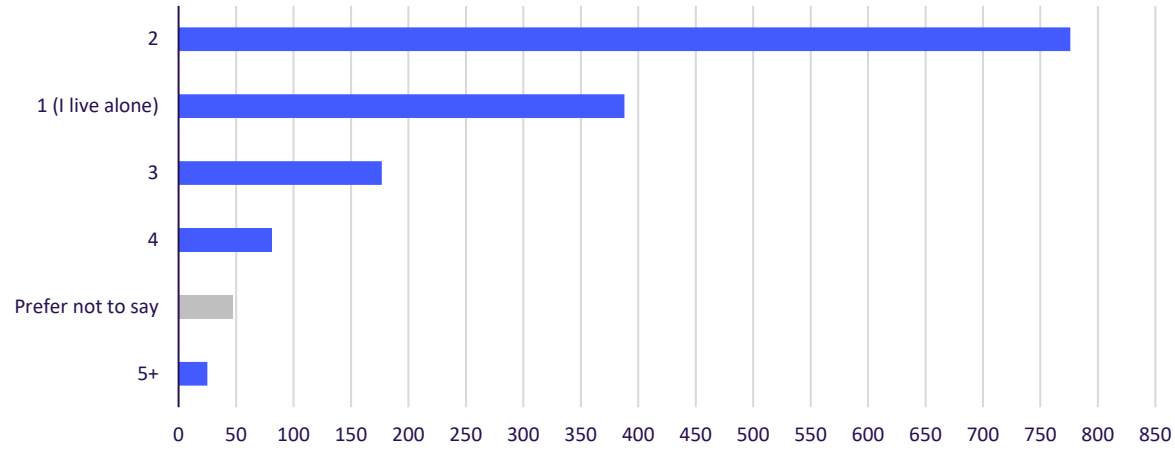
Q45 What is your approximate household income (before tax)?

Responses: 1081



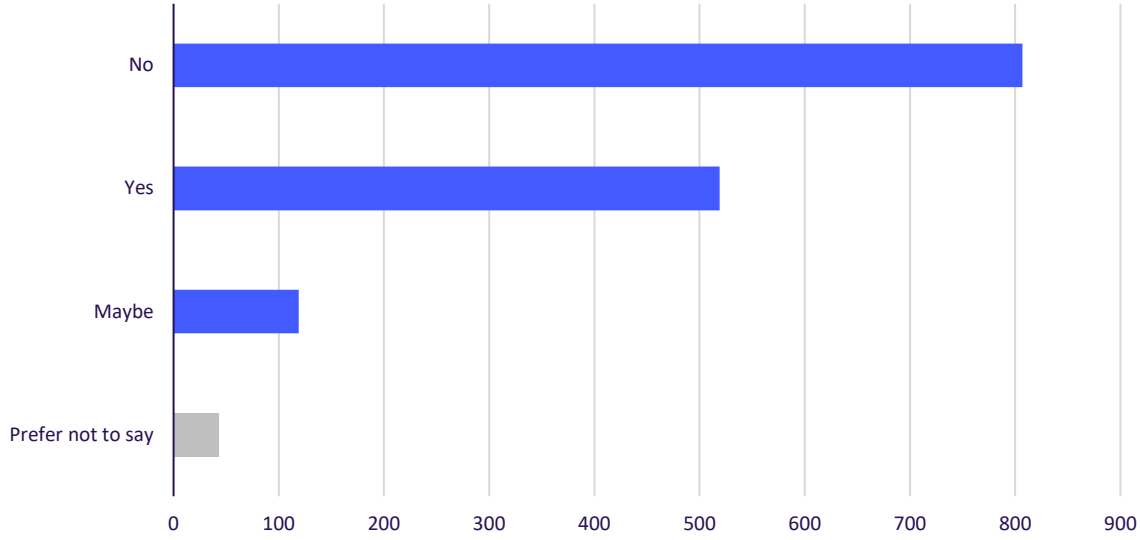
Q46 How many people live in your household (including yourself)?

Responses: 1494



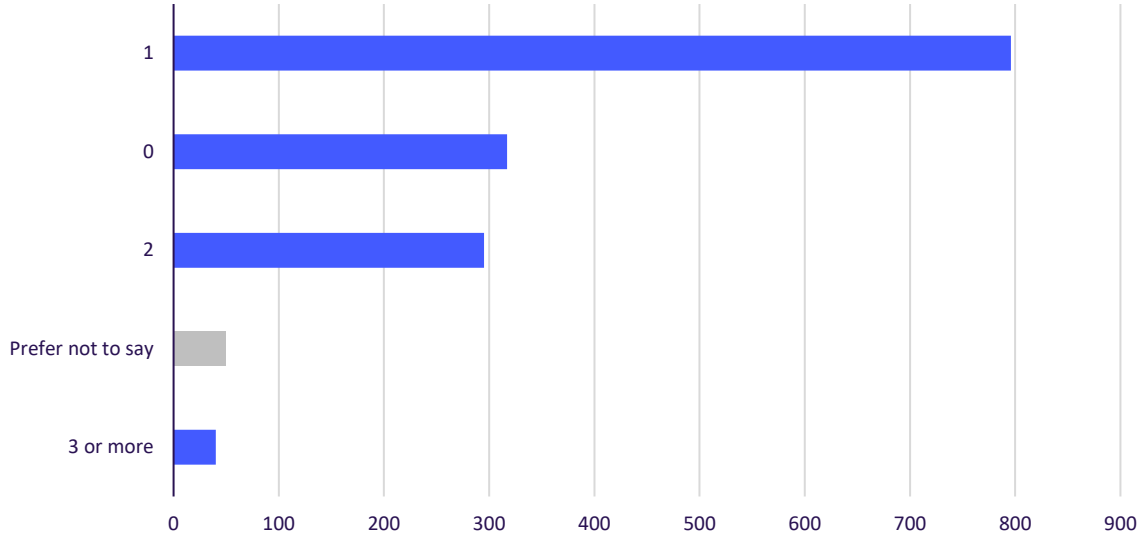
Q47 Does anyone in your household rely on you for transport to healthcare appointments?

Responses: 1488



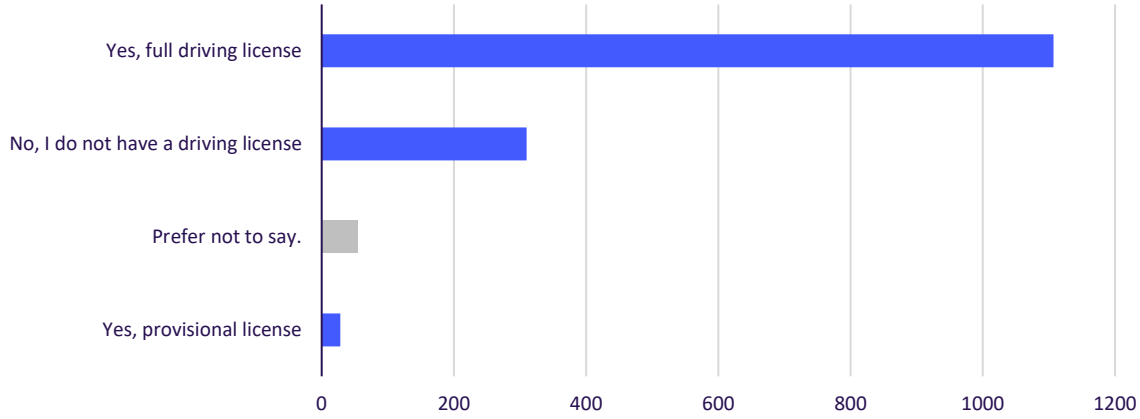
Q48 How many cars or vans are available for use by your household?

Responses: 1498



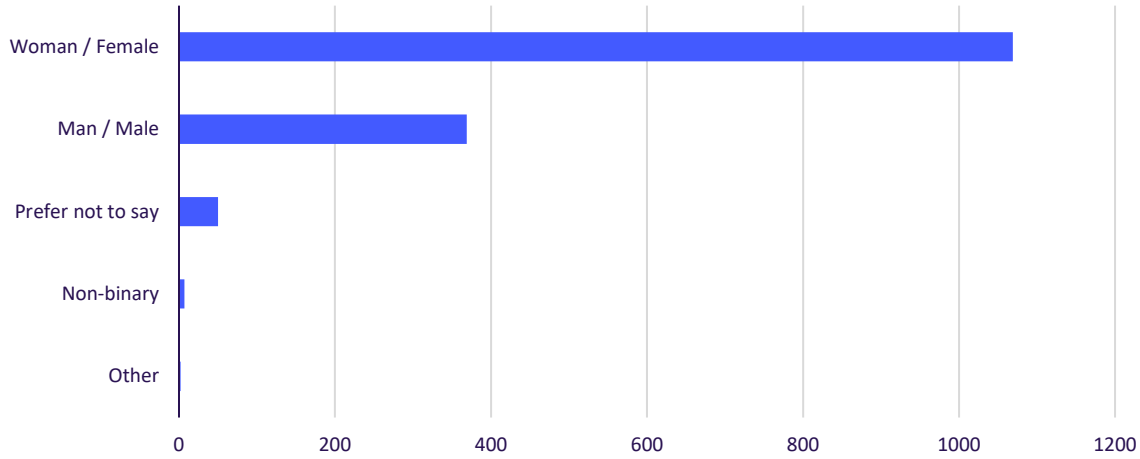
Q49 Do you personally hold a full or provisional driving licence?

Responses: 1500



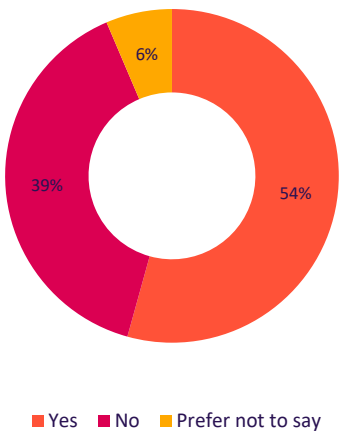
Q50 What best describes your gender?

Responses: 1497



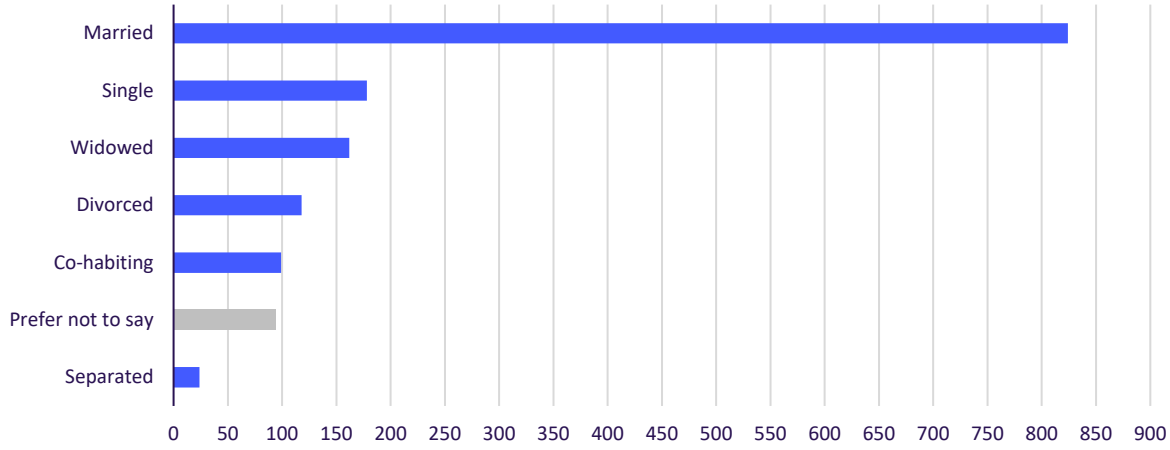
Q51 Do you consider yourself to be disabled, or do you have a long-term health condition?

Responses: 1497



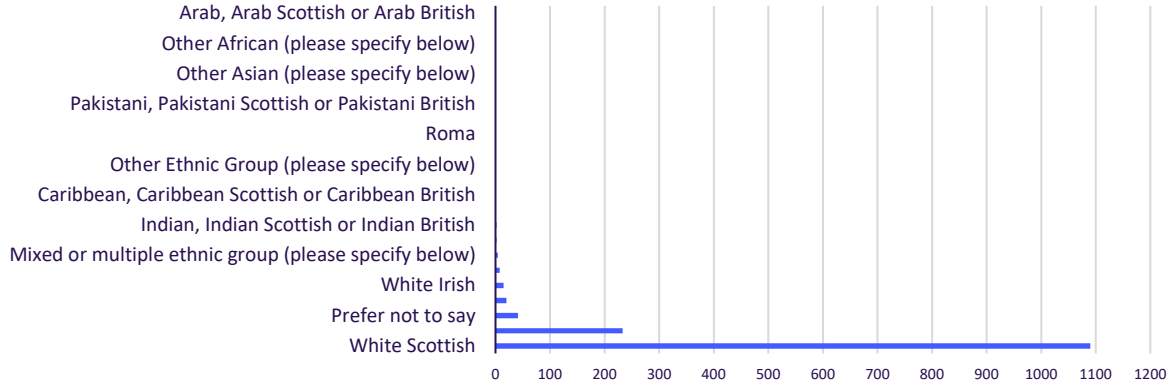
Q52 What is your marital or family status?

Responses: 1499



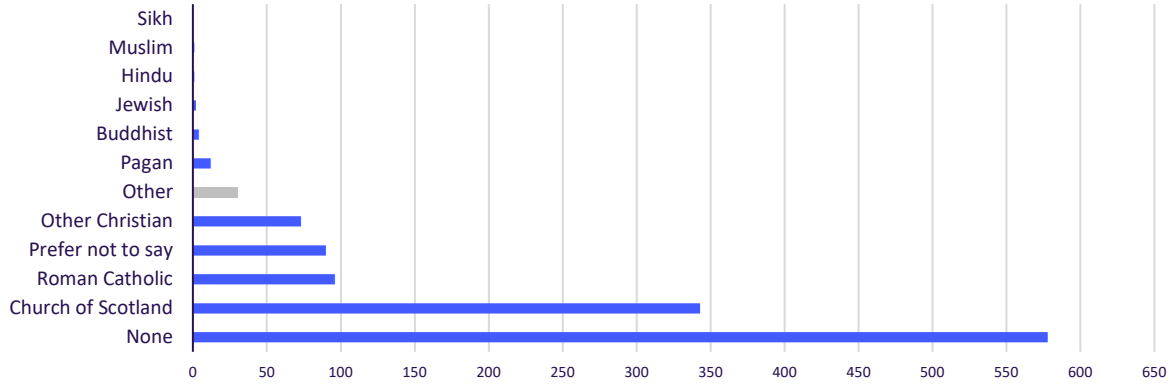
Q53 & Q54 What is your ethnic group?

Responses: 1419



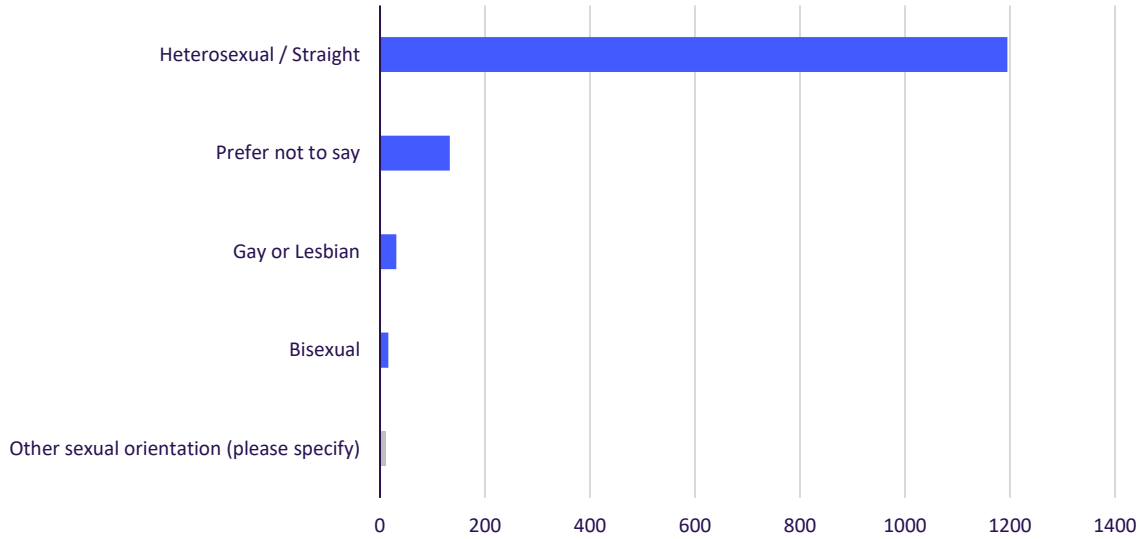
Q55 What religion, religious denomination or body do you belong to, if any? (Please select one option)

Responses: 1230



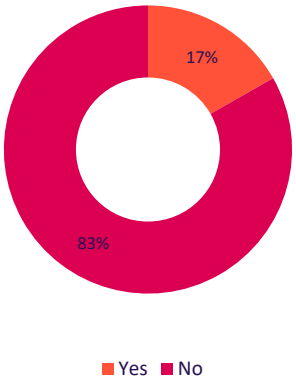
Q56 What is your sexual orientation?

Responses: 1385



Q57 Would you be interested in telling us more in a quick conversation?

Responses: 1480



Q58 If yes, please leave your name; and email address (e.g. John Doe; John.Doe@gmail.com) so we can get in touch:

Responses: 264

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