



# Transport to Health – Case for Change

## APPENDIX

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## About this appendix

This Appendix accompanies the SEStran Transport to Health Case for Change. It brings together two supporting elements of the evidence base that were originally part of the full report: the Equality Impact Assessment (EqIA) and the public consultation Survey Response Overview. Both are referenced from, and should be read alongside, the main Case for Change report.

# **PART 1: Equality Impact Assessment (EqIA)**

The Equality Impact Assessment (EqIA) has been undertaken at the Case for Change stage of SEStran's development of a Regional Transport to Health Strategy, in line with the Scottish Transport Appraisal Guidance (STAG) requirement to consider equality and socio-economic impacts from the earliest stage of policy development. A summary of the EqIA's key findings is included in the main Case for Change report; the full assessment, including detailed analysis against each protected characteristic, is presented in the following pages.

**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 experience 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+)

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#### 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.

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### 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.

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## 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.

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## 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

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### 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)

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- 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

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### **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.

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### **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)

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### 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

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### 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

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### 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

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### 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

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### 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

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### 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

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### 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).

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### 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

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### 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

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- 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

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### **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).

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### **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

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### 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

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### 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.

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## 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

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### 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

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### Single parents

- Often from lower-income households
- Limited flexibility for complex journey planning
- Higher likelihood of missing appointments

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### Mitigation

Carers' needs recognised in TPO5. Community transport can provide family-friendly options, demand-responsive transport could accommodate children.

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### 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

# Part 2: Survey Response Overview

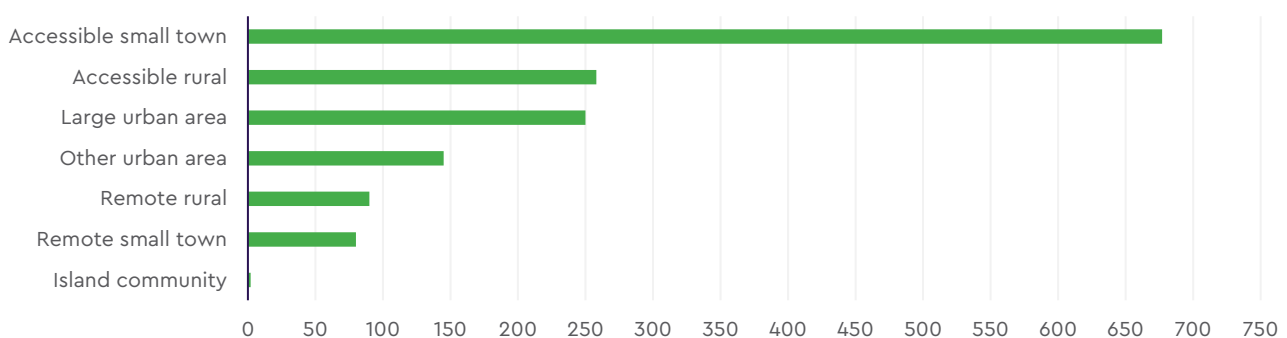
This section presents the full set of responses to the public consultation survey that informed the Case for Change. The consultation was delivered through a public survey supported by a paid advertising campaign over three weeks, with the survey itself open for six weeks. It was primarily accessible online, with paper copies available on request. Headline findings and themes are summarised in the Public consultation summary section of the main report; the detailed question-by-question responses are reproduced here in full.

## Q1 What are the first 4-5-digits of your postcode? (e.g., EH8 1, TD15 2)

Responses: 1346

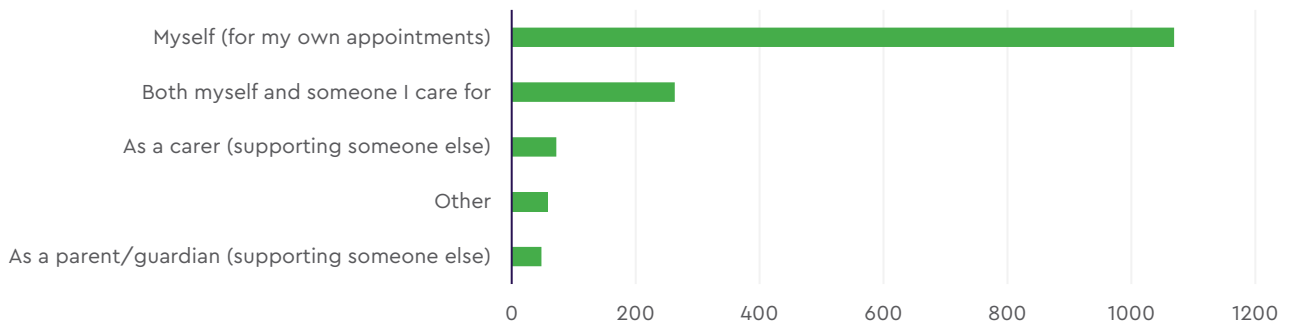
## Q2 Which do you feel best describes where you live?

Responses: 1502



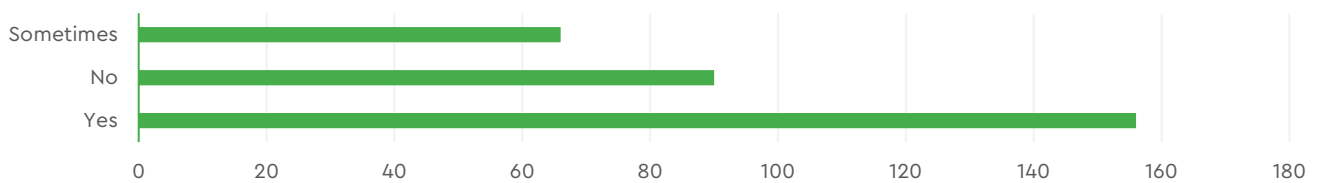
### Q3 Who are you usually travelling for when attending healthcare appointments?

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.

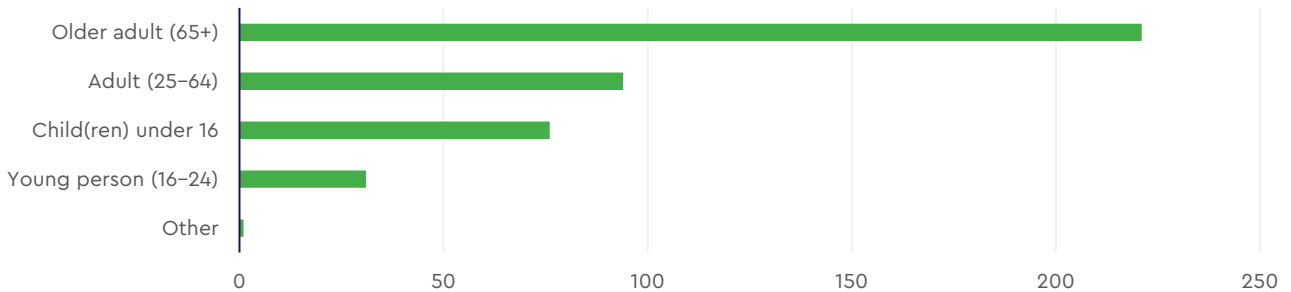
When the person I care for can't drive, it takes all day to go to hospital and back home

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.

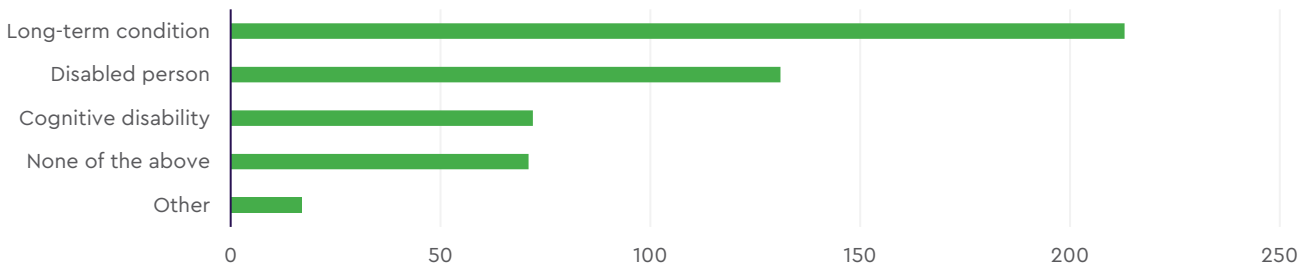
**Q6 Who do you usually support when travelling to healthcare appointments? (Tick all that apply)**

**Responses: 423**



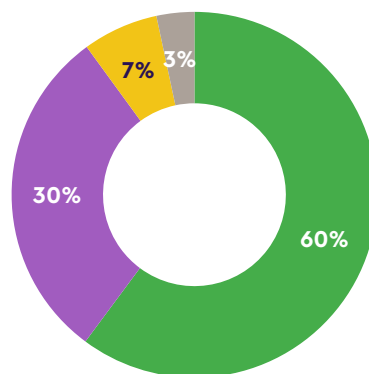
**Q7 Does the person you support fall into any of the below categories (Tick all that apply)**

**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**



■ Yes ■ No ■ Maybe ■ Not sure

**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

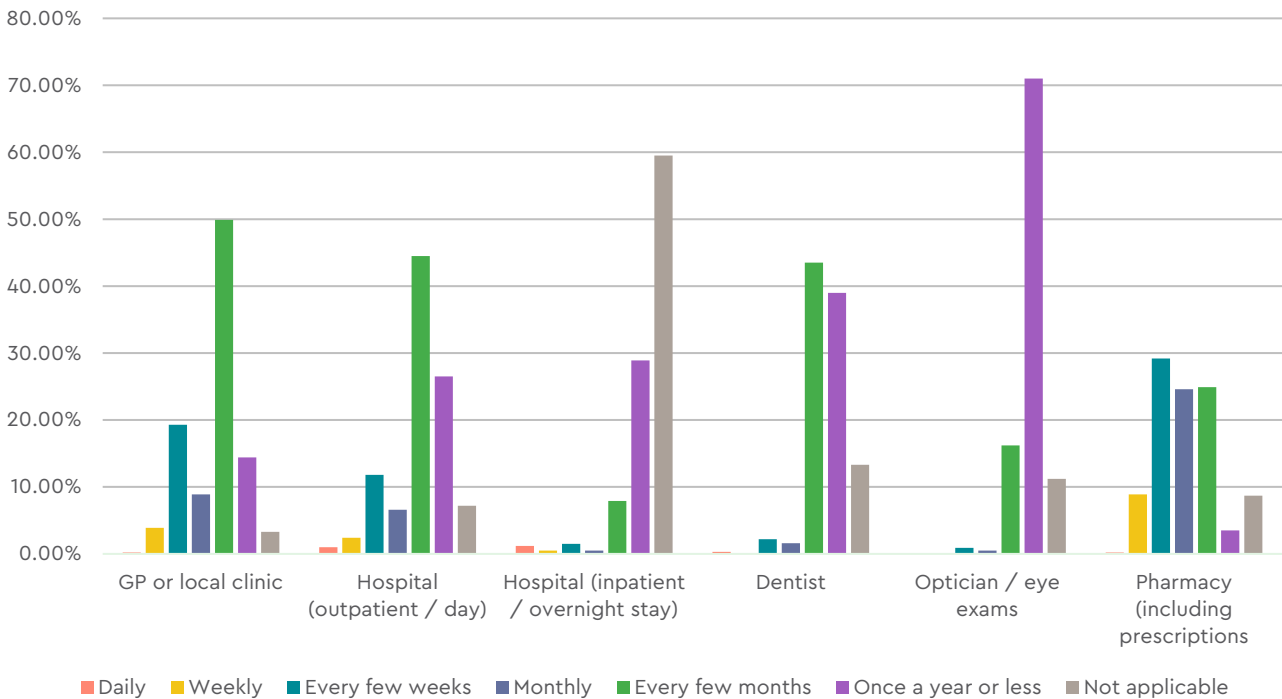
My husband and I both have mobility issues requiring expensive taxi fares which living on benefits we can't afford

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

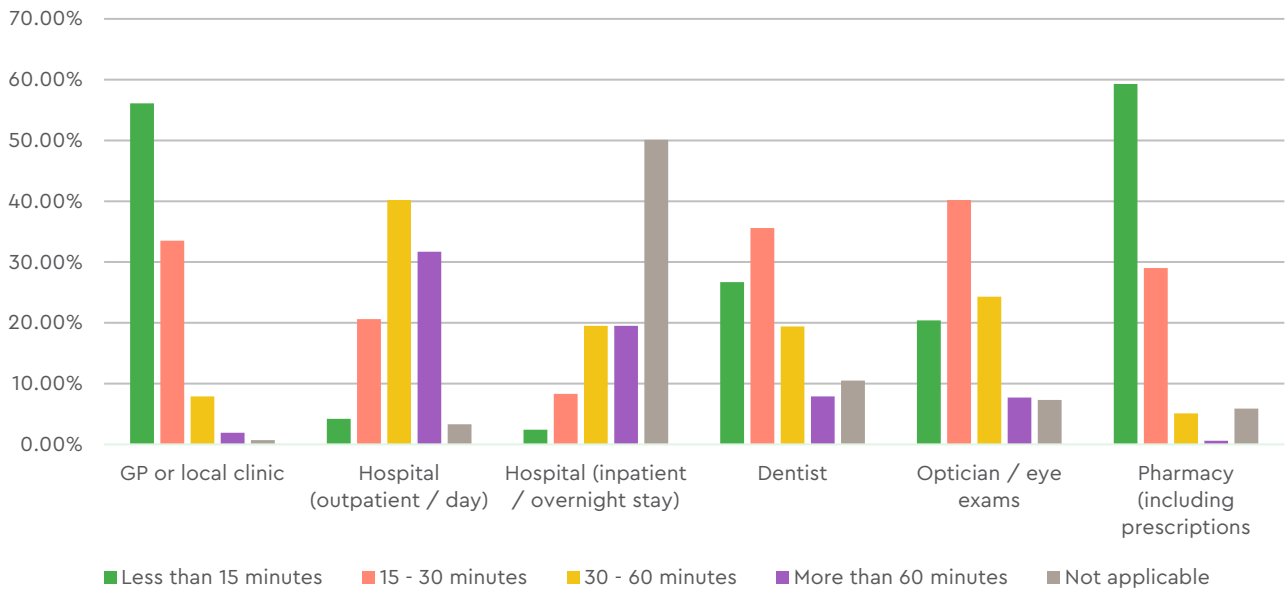
**Q10 In the past 12 months, how often have you or someone you support travelled for the following types of healthcare?**

Responses: 1447



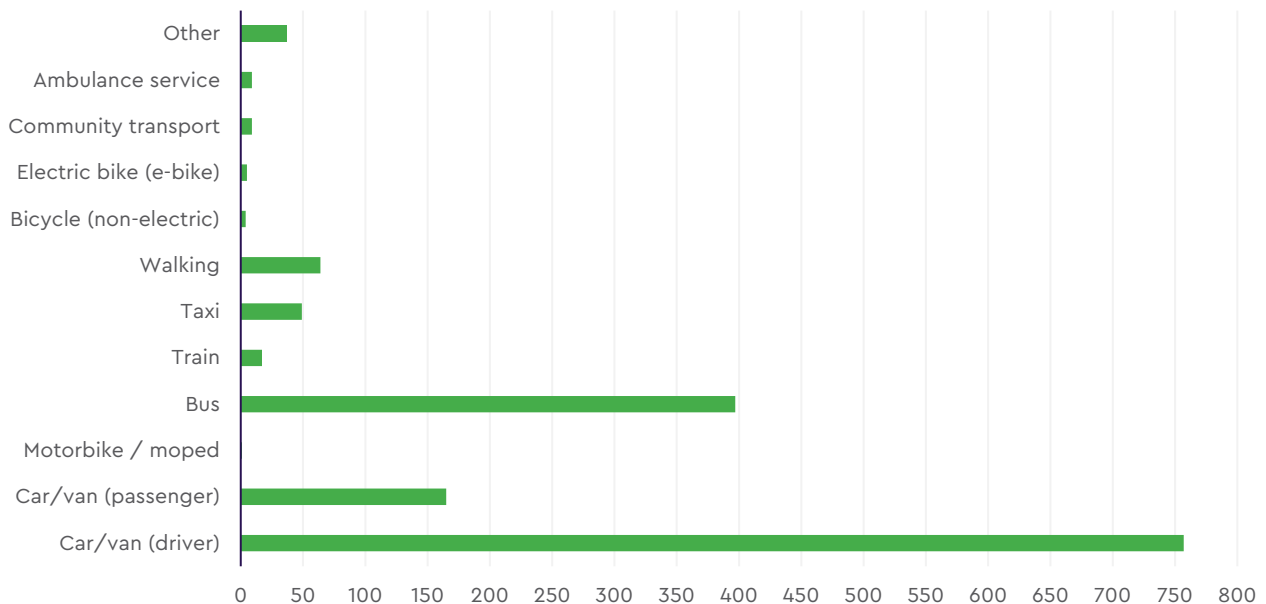
## Q11 How long is your usual journey to a healthcare appointment (one way)?

Responses: 1470



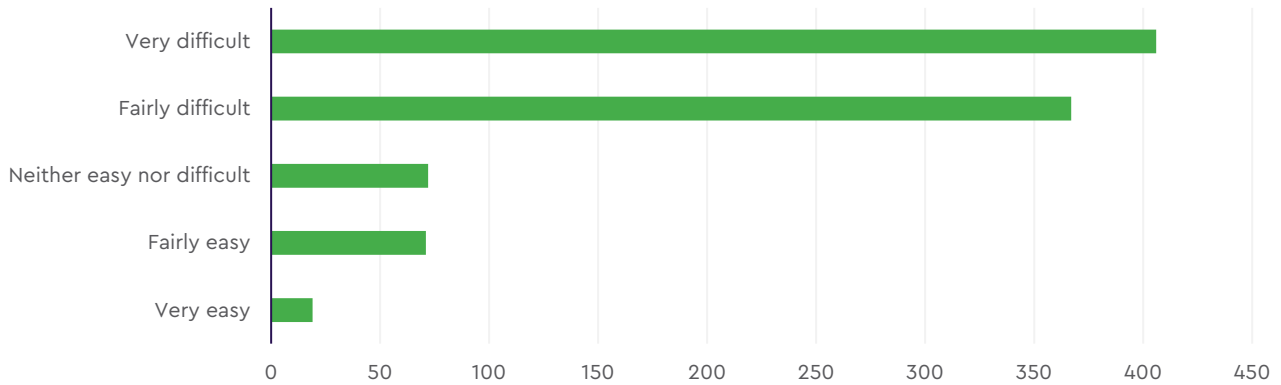
## Q12 What is your main mode of transport you usually use to travel to healthcare appointments?

Responses: 1514



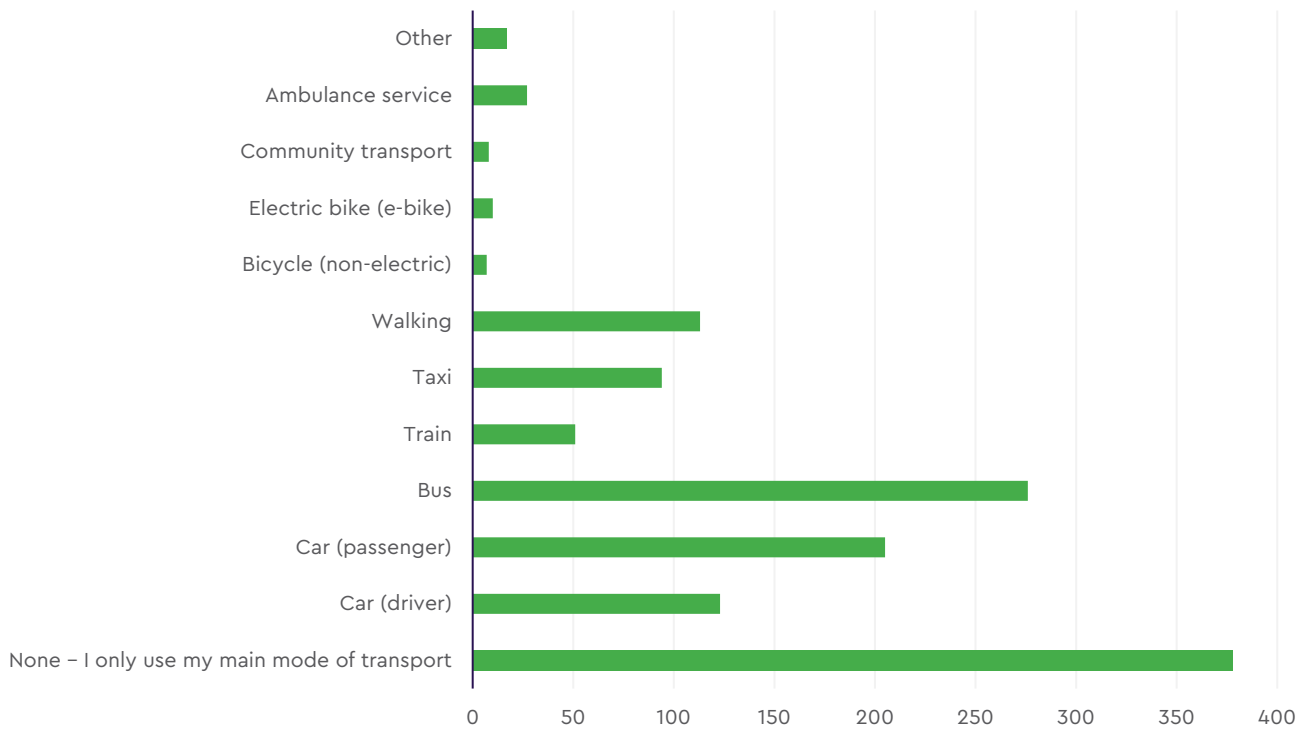
### Q13 How easy would it be to attend without using a car/van?

Responses: 935



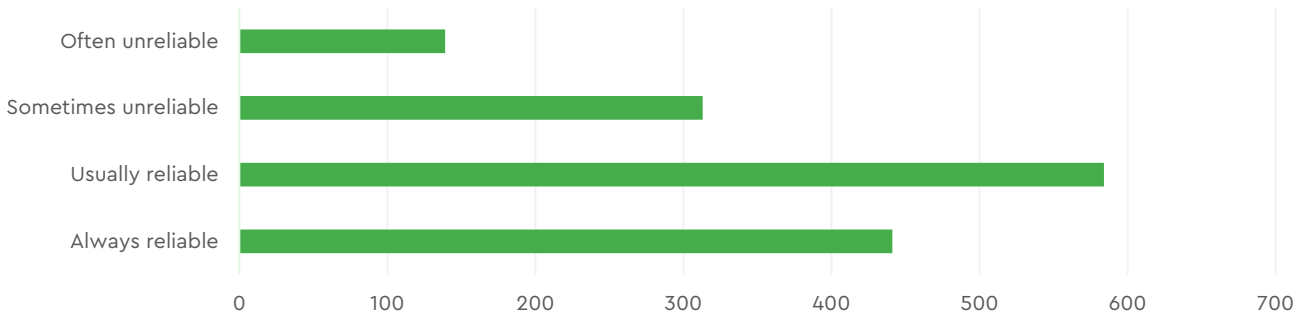
### Q14 Do you rely on any other types of transport to reach healthcare appointments - for example, when your main option isn't available, or for certain trips?

Responses: 1309



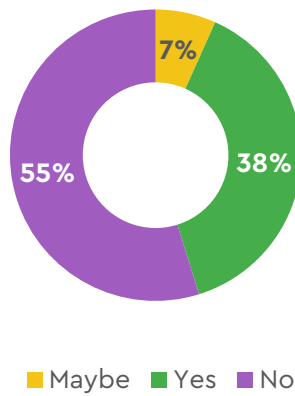
### Q15 How reliable do you find the transport you usually use for healthcare?

Responses: 1477



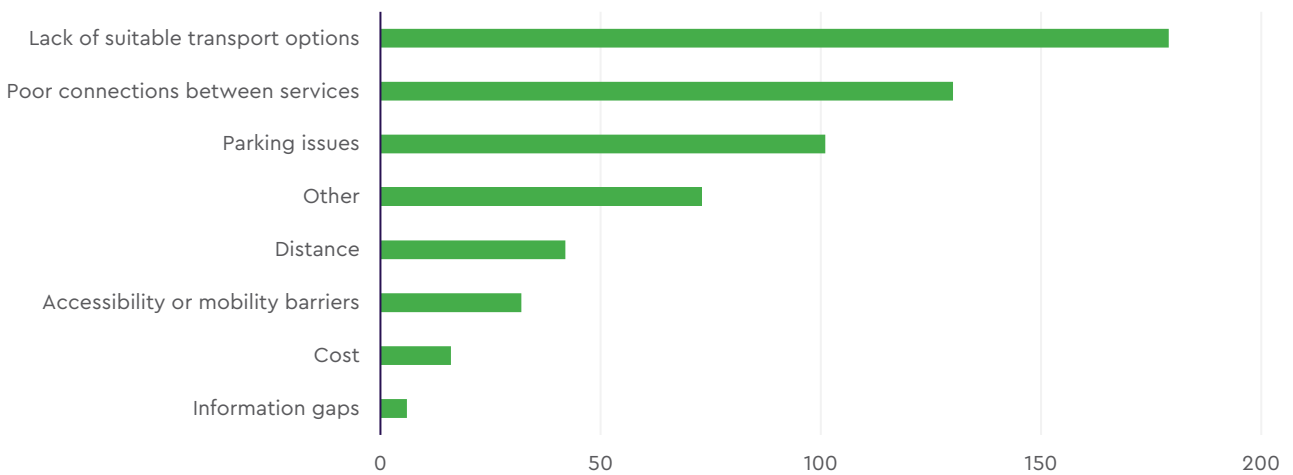
### Q16 Have you ever missed or delayed a healthcare appointment due to transport issues?

Responses: 1505



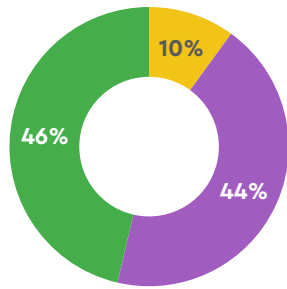
### Q17 If yes, what was the main reason? Tick any that apply:

Responses: 579



### Q18 Have transport issues ever affected your health or wellbeing?

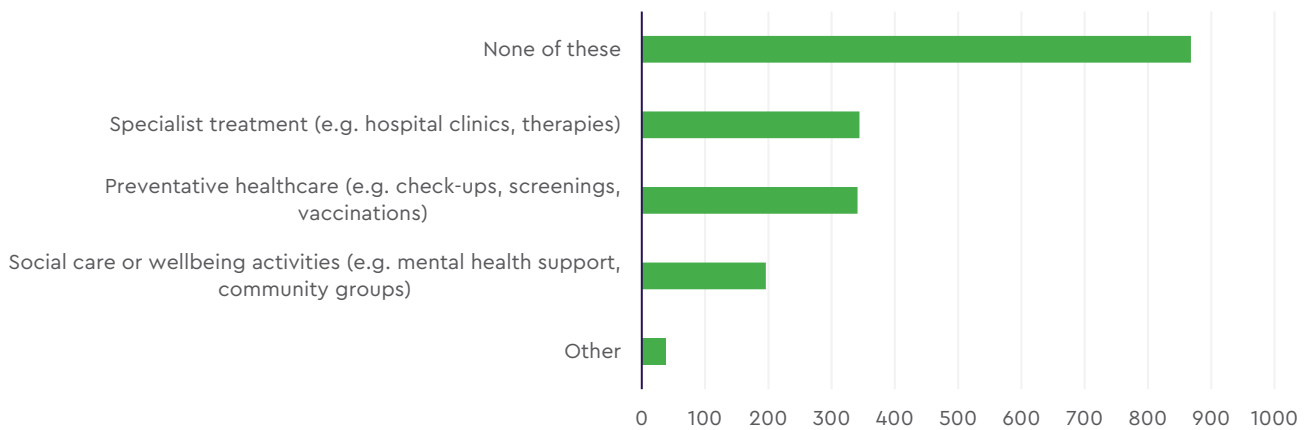
Responses: 1499



■ Maybe ■ No ■ Yes

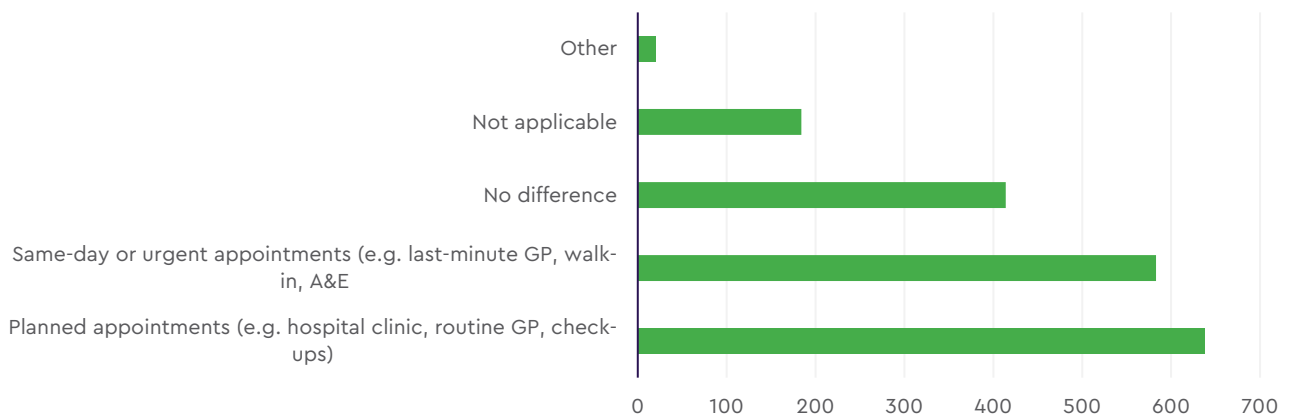
### Q19 Have transport difficulties ever prevented you from accessing any of the following? (Tick all that apply)

Responses: 1786



### Q20 Do transport challenges affect you differently depending on the type of appointment? (Tick all that apply)

Responses: 1839



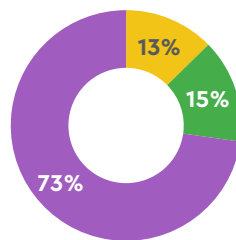
**Q21 Please briefly tell us more about any differences or challenges you experience when travelling to different types of appointments. (Optional)**

**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?**

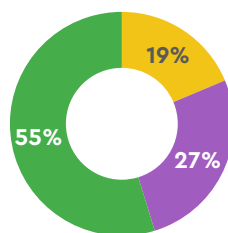
**Responses: 1487**



■ Sometimes ■ Yes ■ No

**Q23 Are you eligible for and do you use a free bus pass or other travel concessions?**

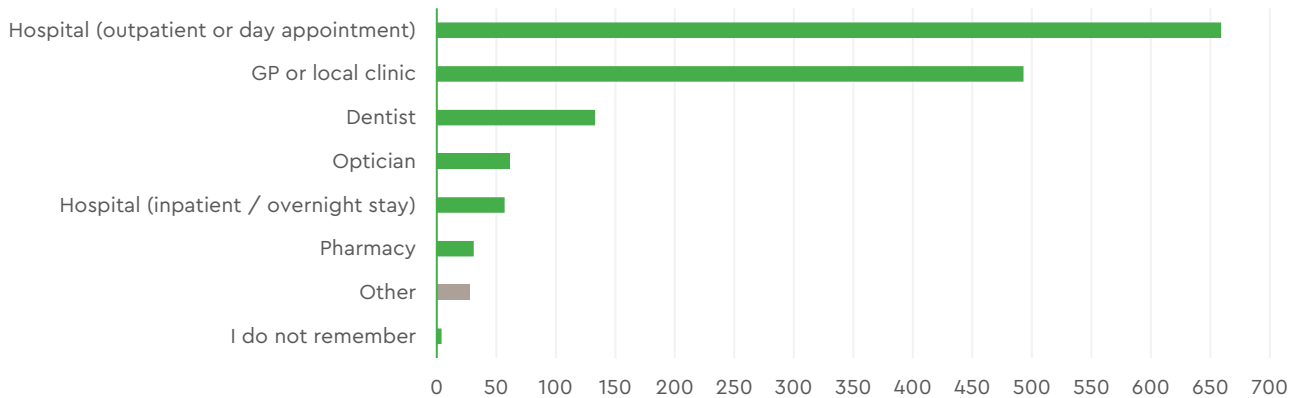
**Responses: 1484**



■ Yes, but I do not use them ■ No ■ Yes, and I use them

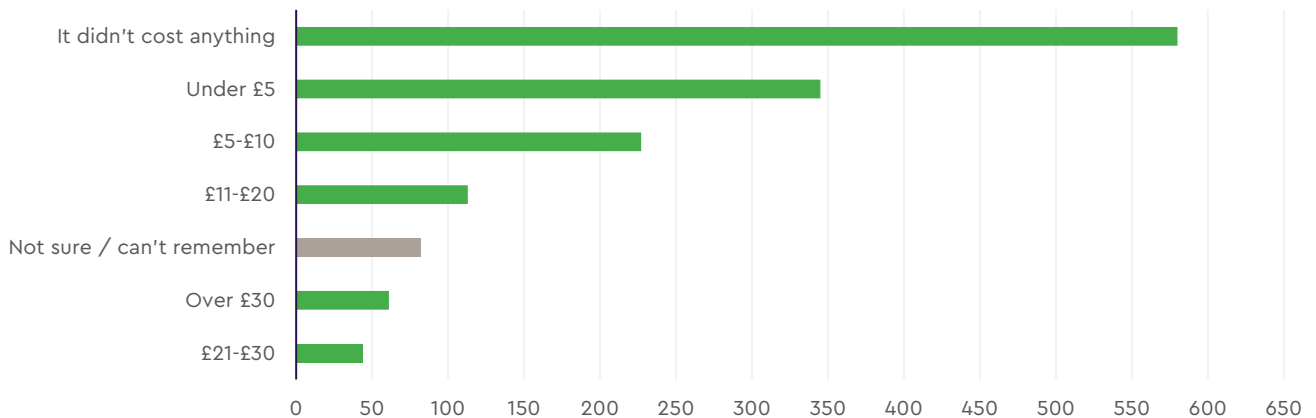
## Q24 Thinking about your most recent healthcare appointment, what type of appointment was it?

Responses: 1466



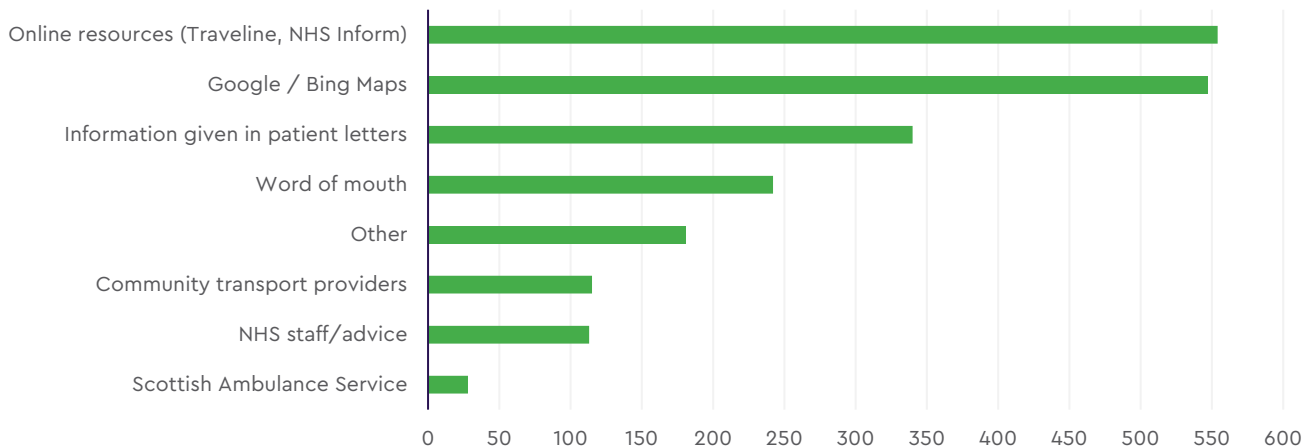
## Q25 Roughly, how much did your return journey cost for this appointment?

Responses: 1452



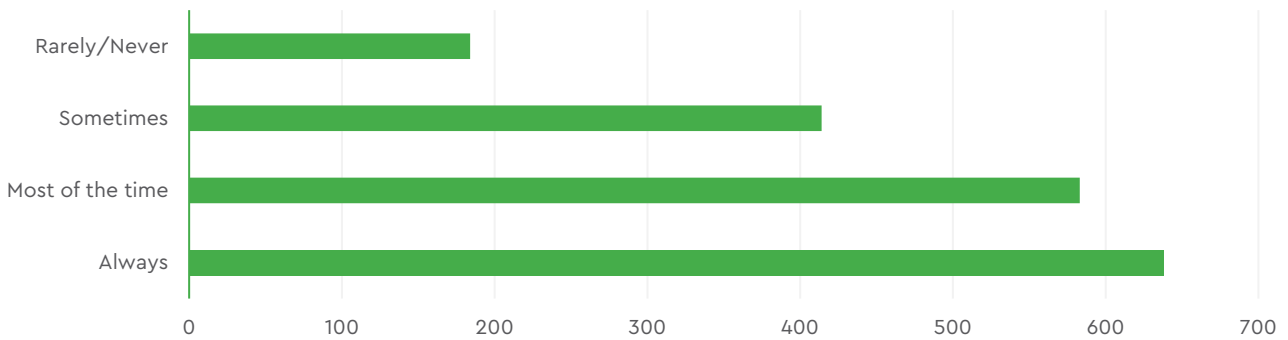
## Q26 Where do you usually get information on travel options to healthcare? (tick all that apply)

Responses: 2120



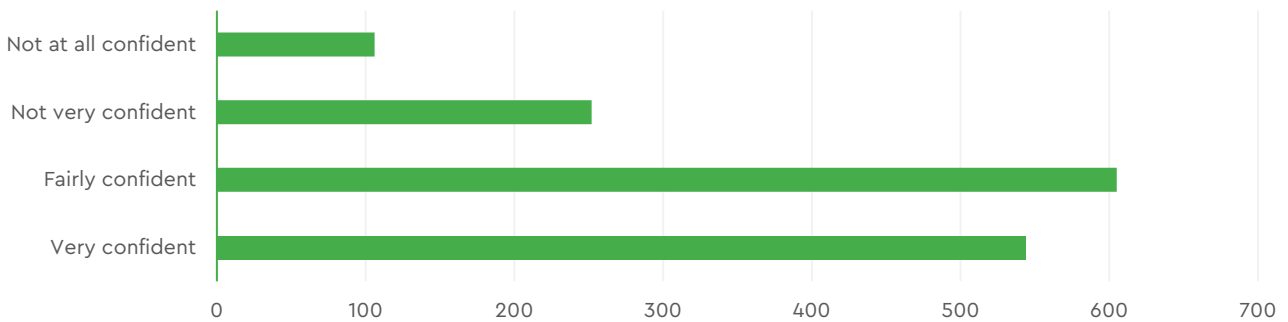
**Q27** The information I need about travel (routes, times, reimbursement, carer support) is easy to find and understand.

Responses: 1819



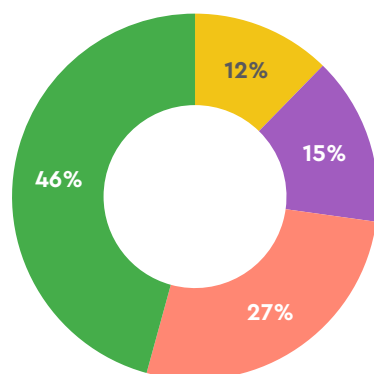
**Q28** How confident are you using online/digital tools to find travel information or book transport?

Responses: 1507



**Q29** Do you usually use online or digital tools to find travel information or book transport?

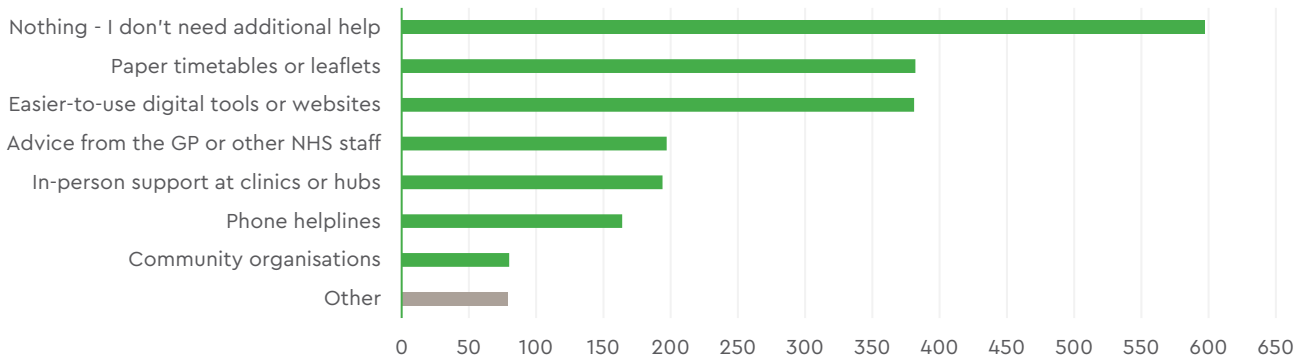
Responses: 1511



■ Rarely ■ Never ■ Sometimes ■ Yes, usually

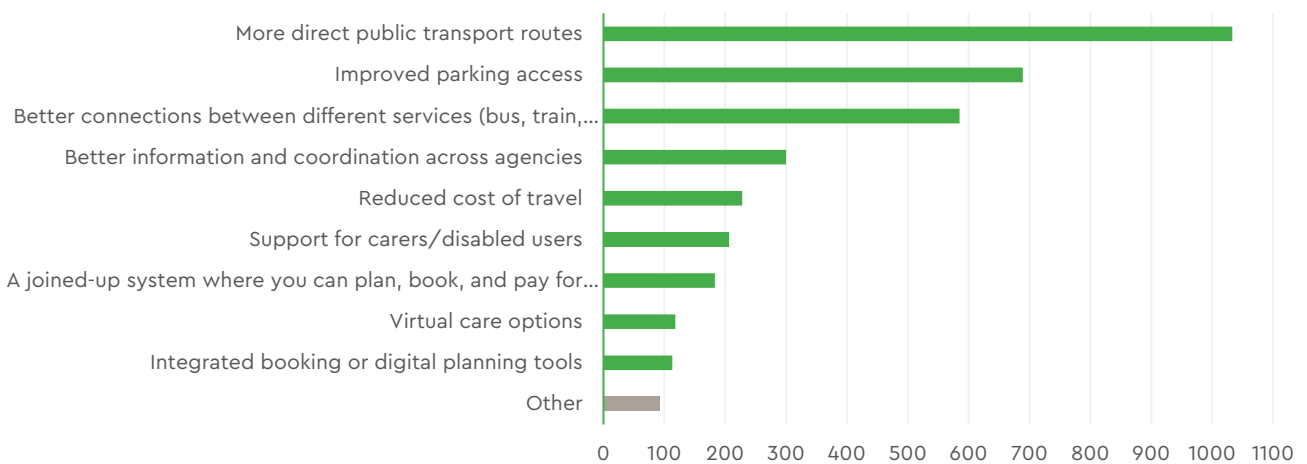
### Q30 What would make it easier for you to find travel information or book transport?

Responses: 2074



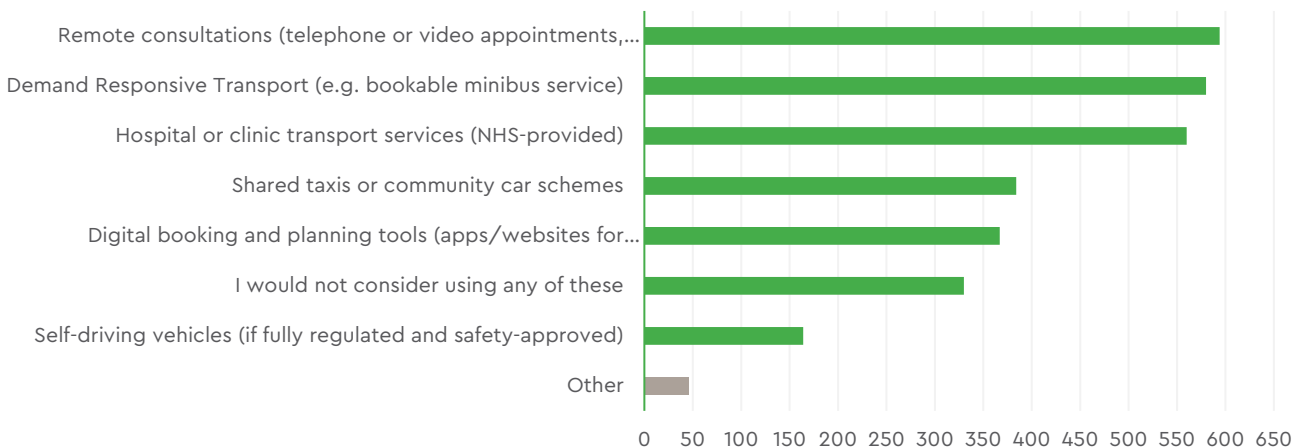
### Q31 What would be the top 3 things that would most help you get to healthcare appointments?

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

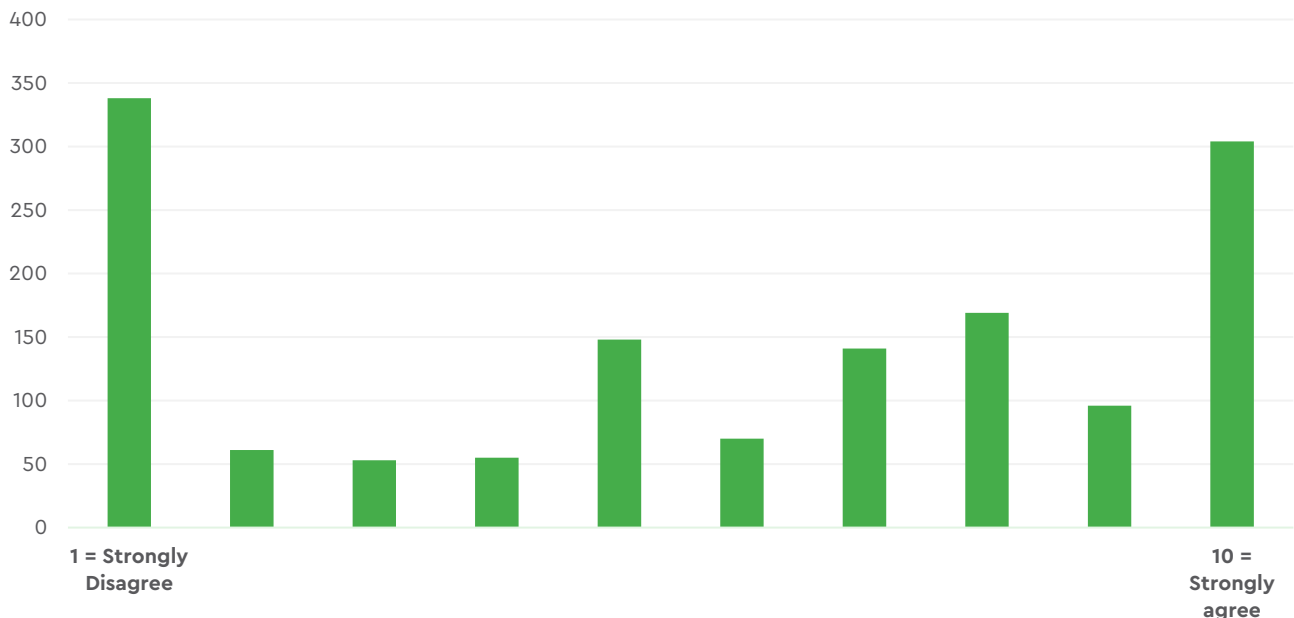
Victoria hospital Kirkcaldy's. Dentist is now in St Andrews 45 mins drive (plus parking) as I cannot get local ... this is very costly in fuel etc and time off work

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

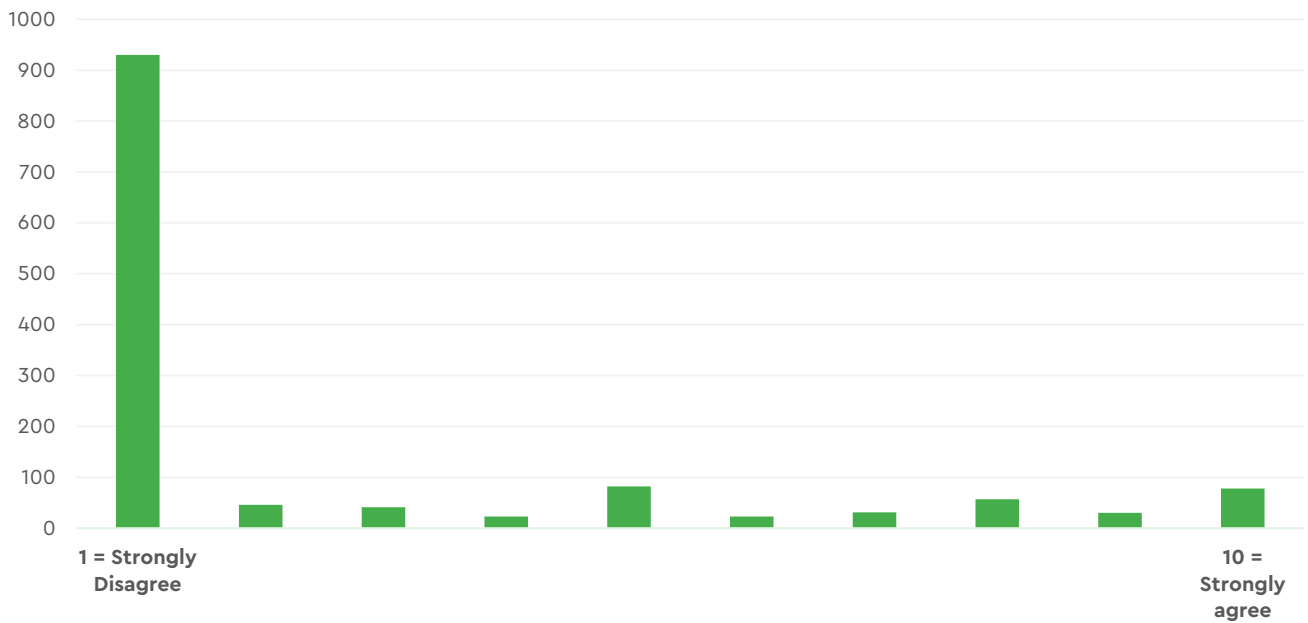
### Q34 Physical disability or mobility issues make travel to healthcare more difficult for me or someone I support.

Responses: 1435



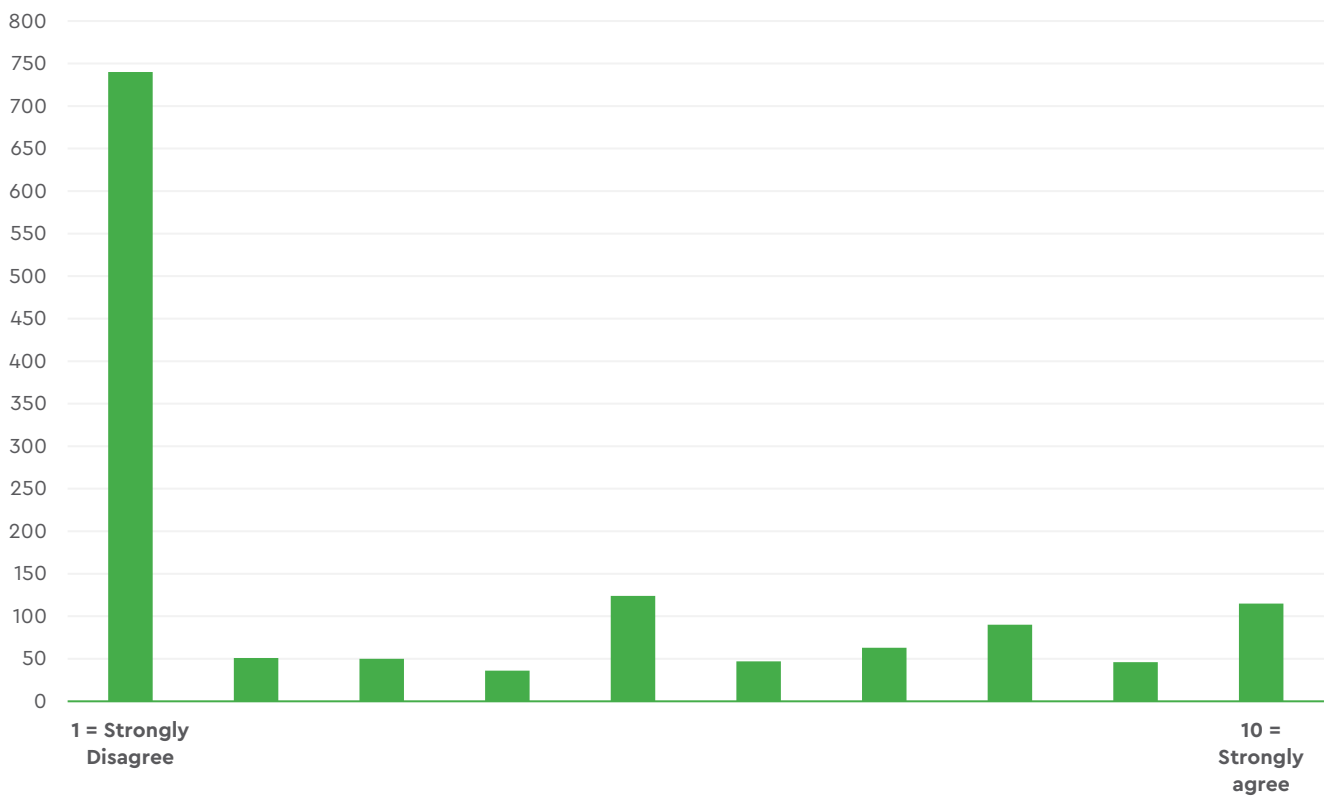
**Q35** A learning disability makes travel to healthcare more difficult for me or someone I support.

Responses: 1341



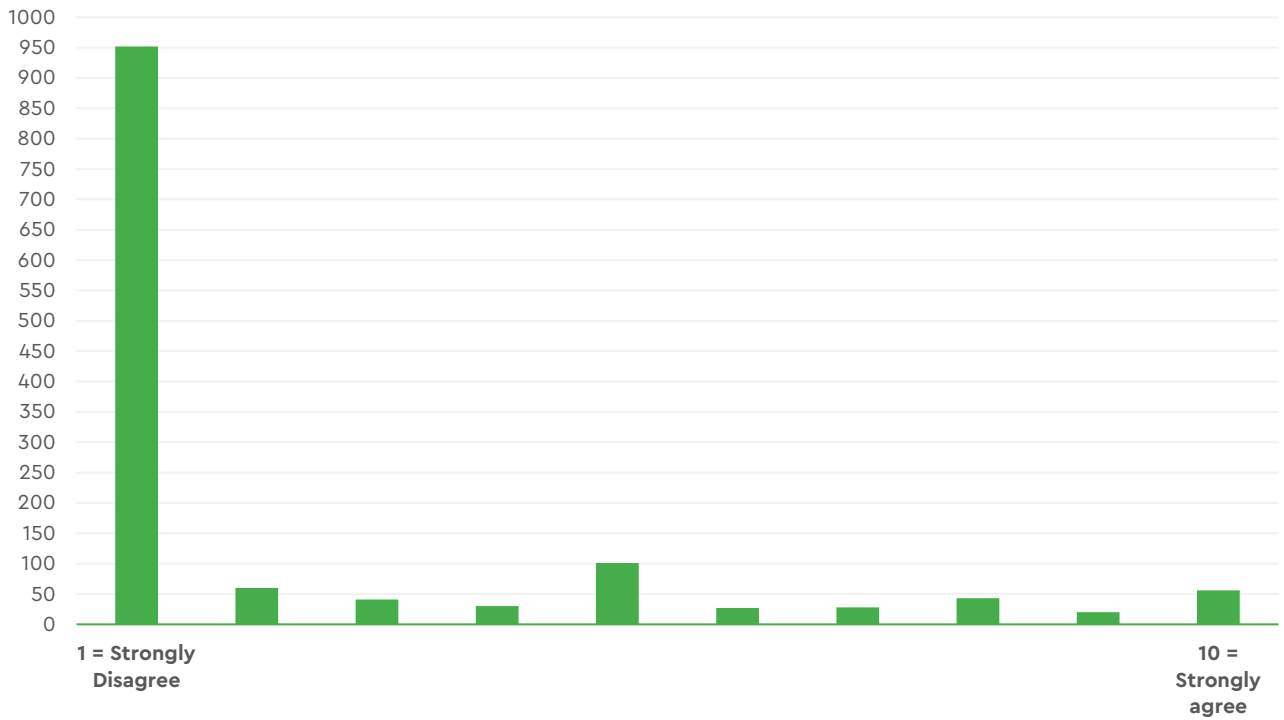
**Q36** Mental health conditions make travel to healthcare more difficult for me or someone I support.

Responses: 1362



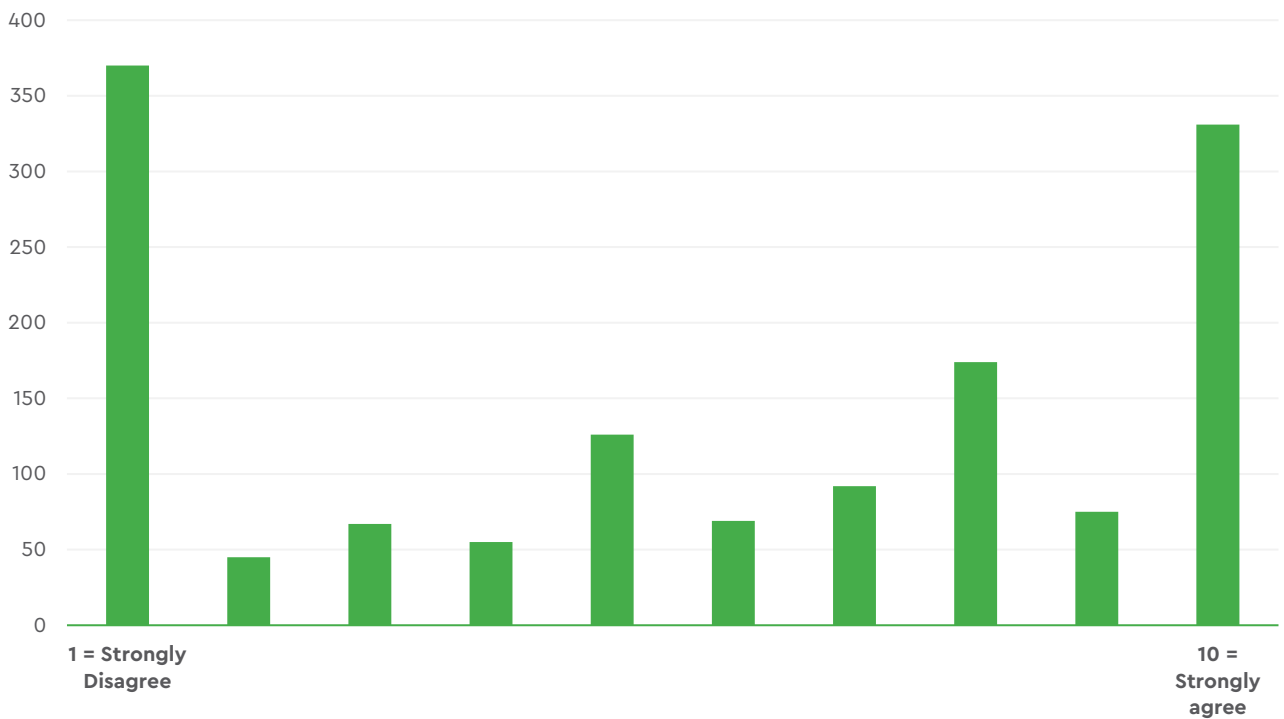
**Q37** Communication or language barriers make travel to healthcare more difficult for me or someone I support.

Responses: 1358



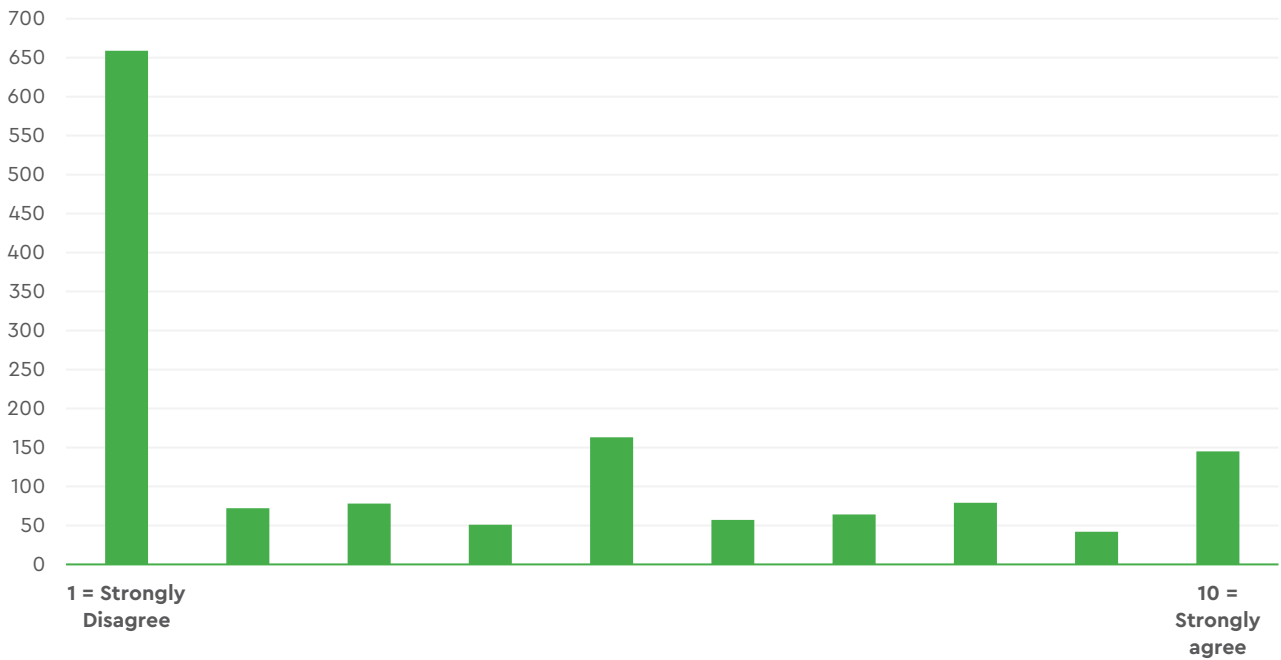
**Q38** Rural isolation or lack of nearby services make travel to healthcare more difficult for me or someone I support.

Responses: 1404



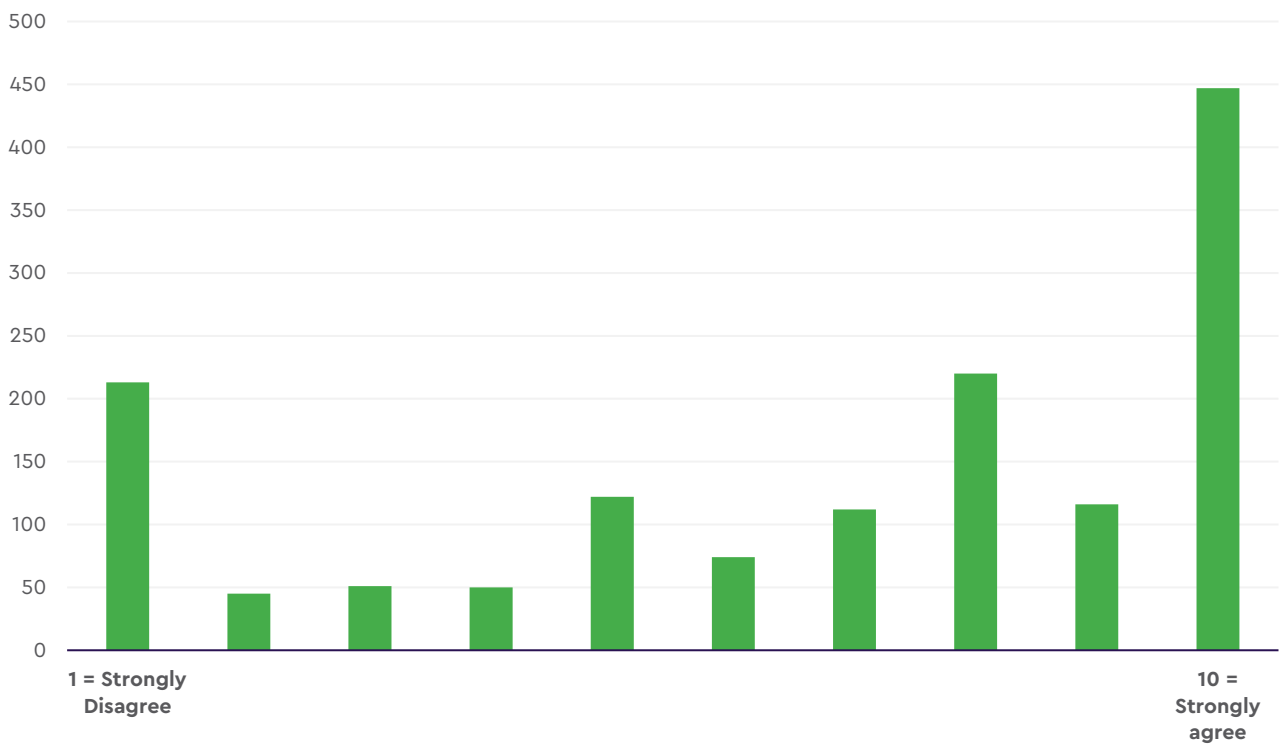
**Q39** The cost of travel makes it more difficult for me or someone I support. Rural isolation or lack of nearby services make travel to healthcare more difficult for me or someone I support.

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.
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

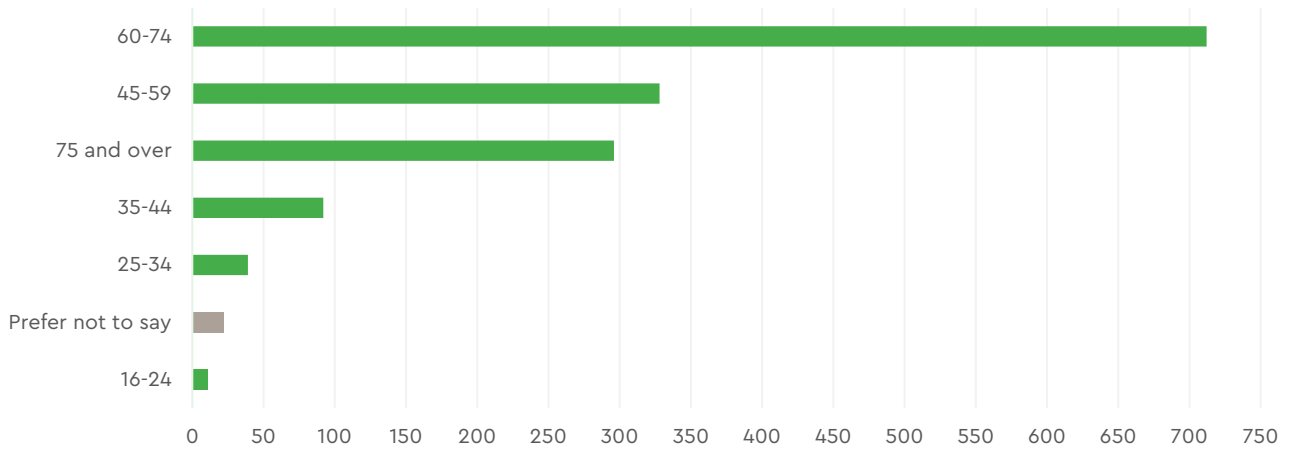
**Q42 Do you have any other comments or suggestions on how transport to healthcare could be improved in your area? (optional)**

**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

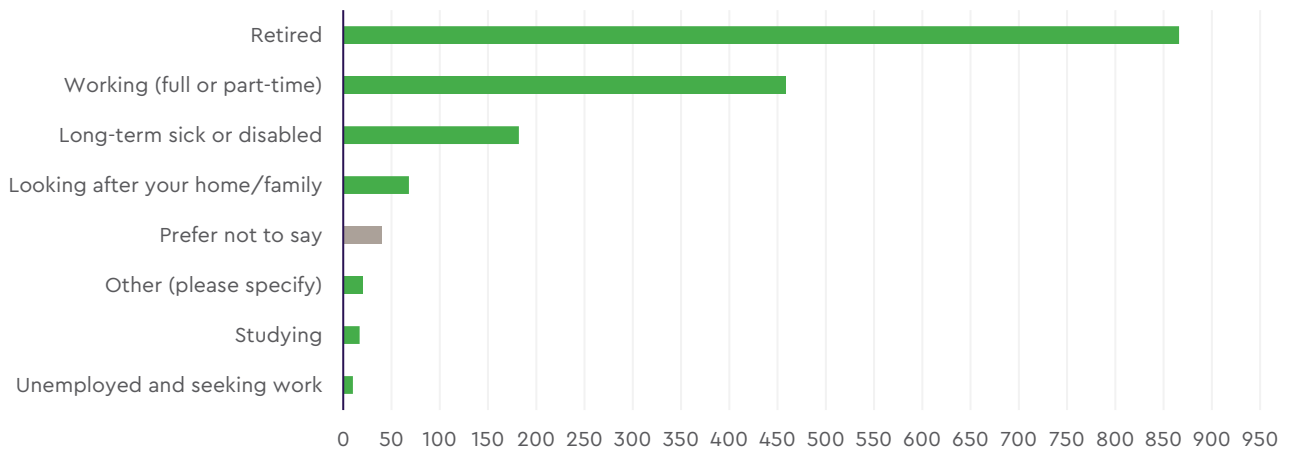
### Q43 Please select your age group

Responses: 1500



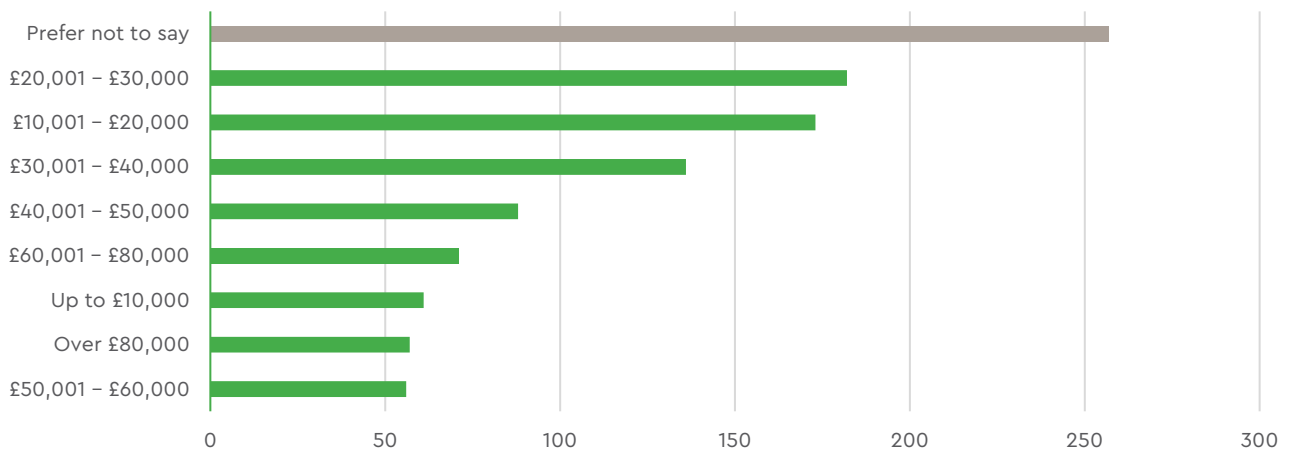
### Q44 What is your current situation? (Tick all that apply)

Responses: 1661



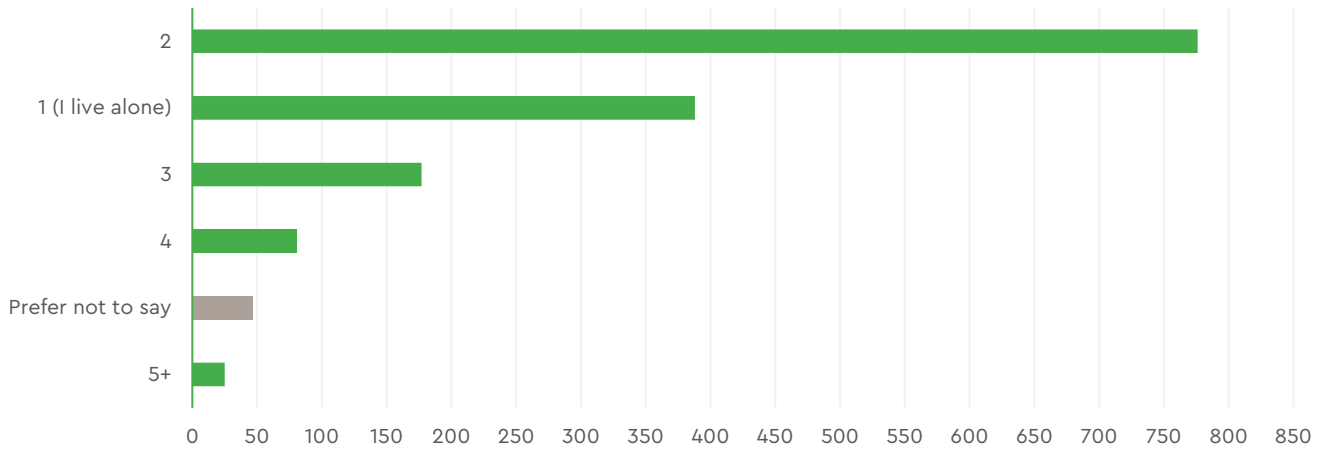
### Q45 What is your approximate household income (before tax)?

Responses: 1081



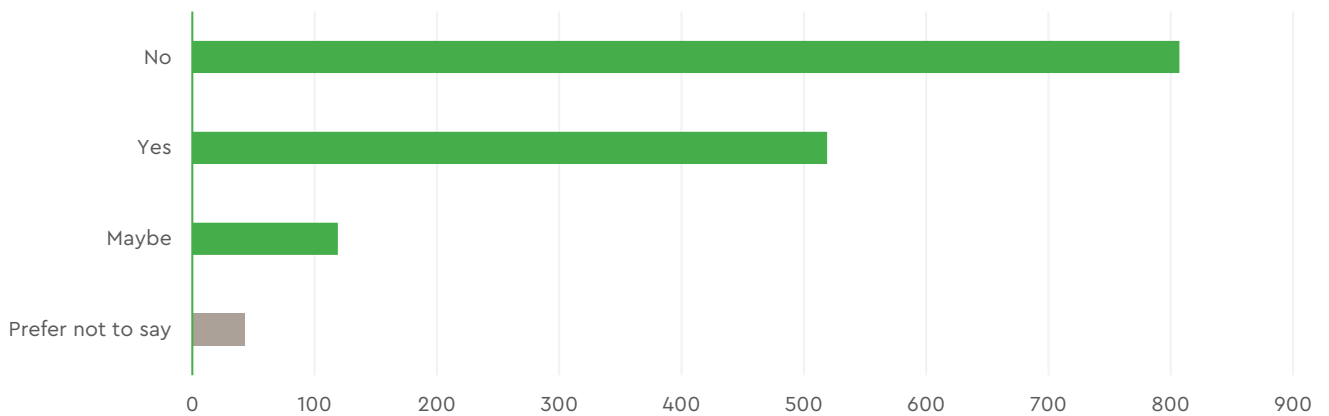
**Q46** How many people live in your household (including yourself)?

Responses: 1494



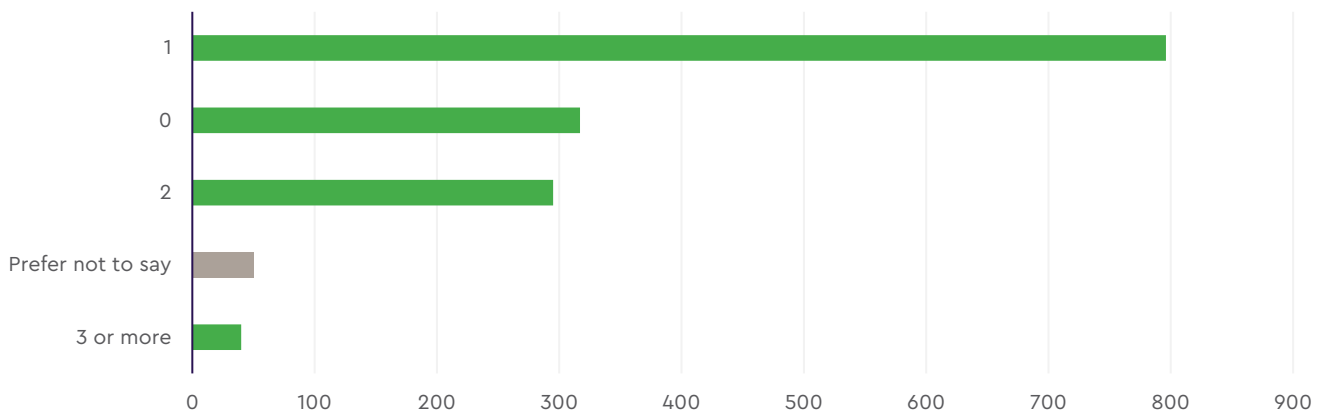
**Q47** Does anyone in your household rely on you for transport to healthcare appointments?

Responses: 1488



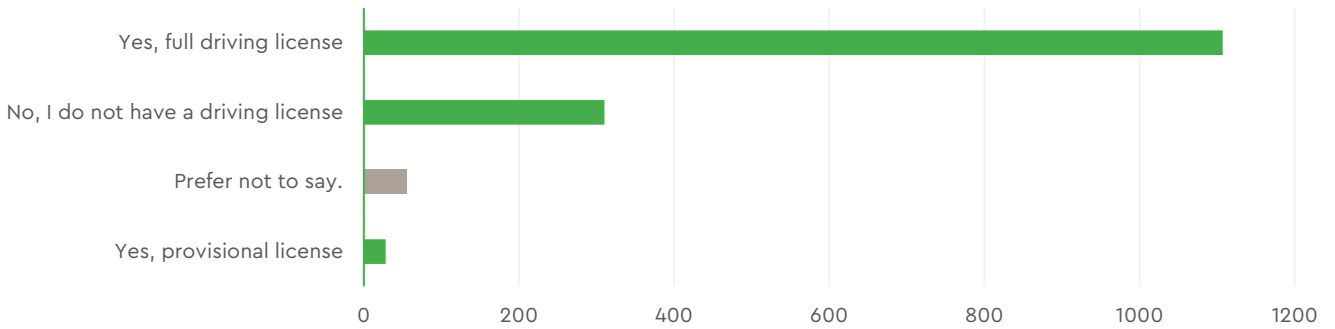
**Q48** How many cars or vans are available for use by your household?

Responses: 1498



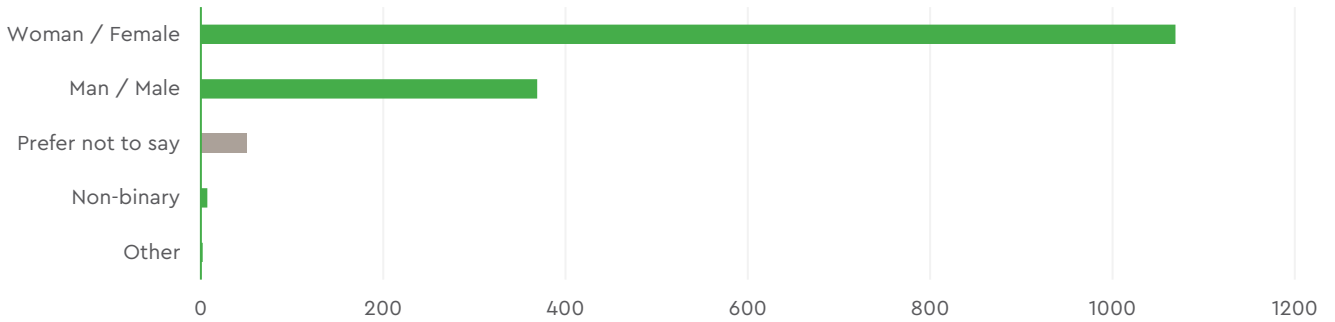
**Q49 Do you personally hold a full or provisional driving licence?**

Responses: 1500



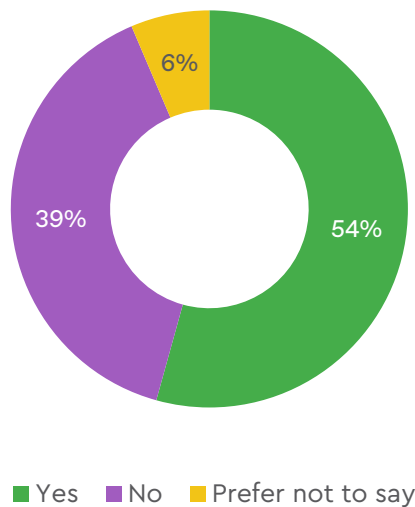
**Q50 What best describes your gender?**

Responses: 1497



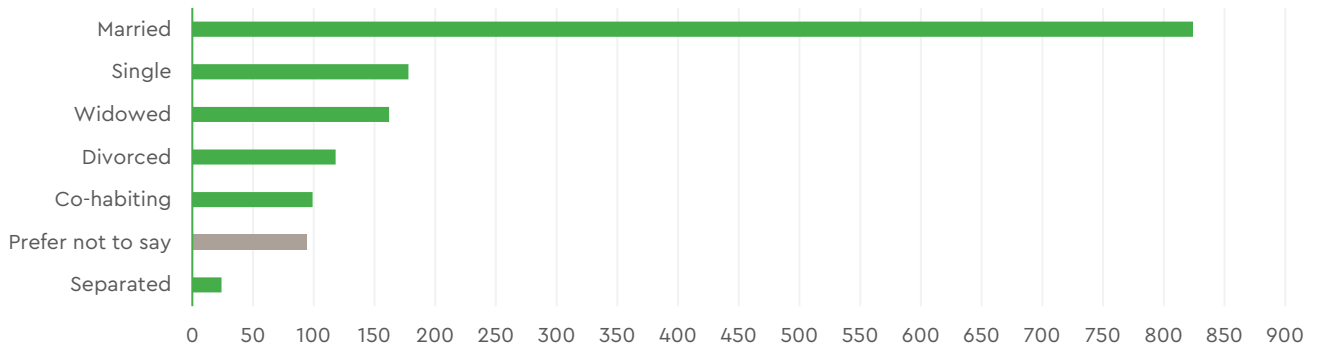
**Q51 Do you consider yourself to be disabled, or do you have a long-term health condition?**

Responses: 1497



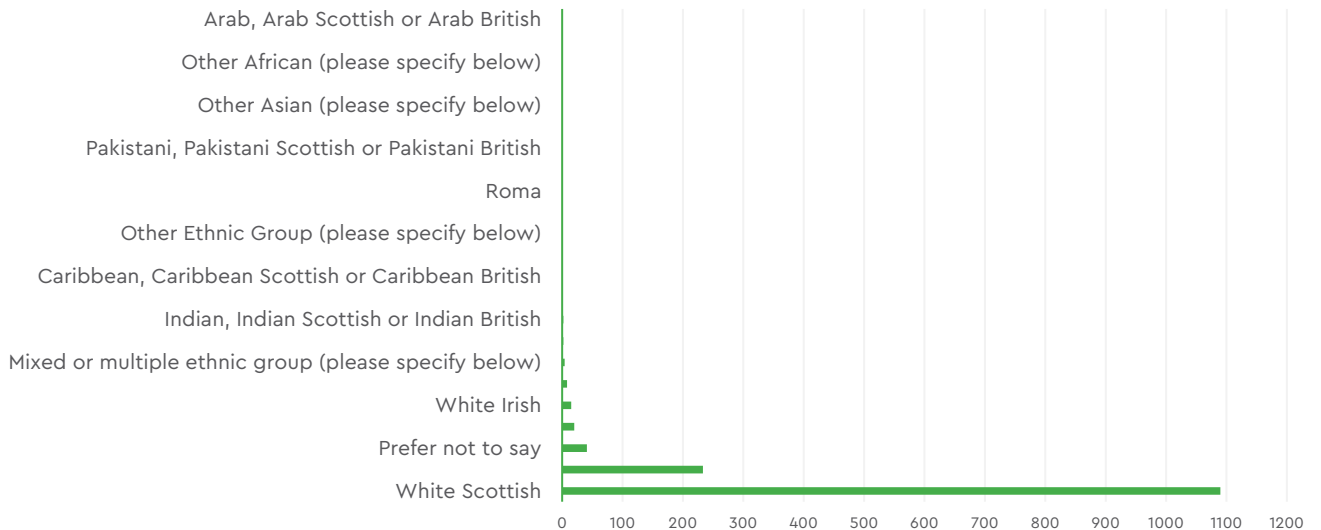
## Q52 What is your marital or family status?

Responses: 1499



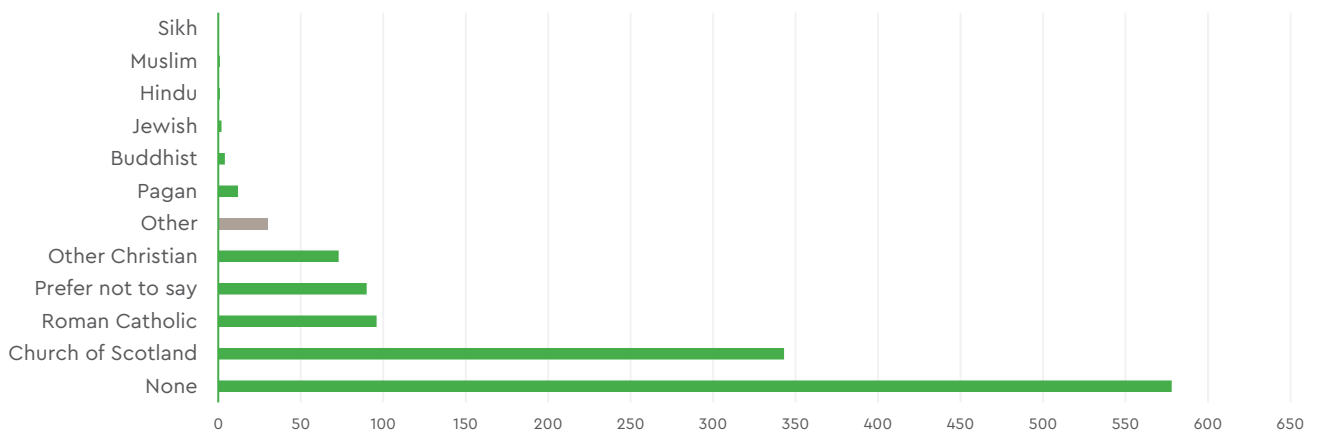
## Q53 & Q54 What is your ethnic group?

Responses: 1419



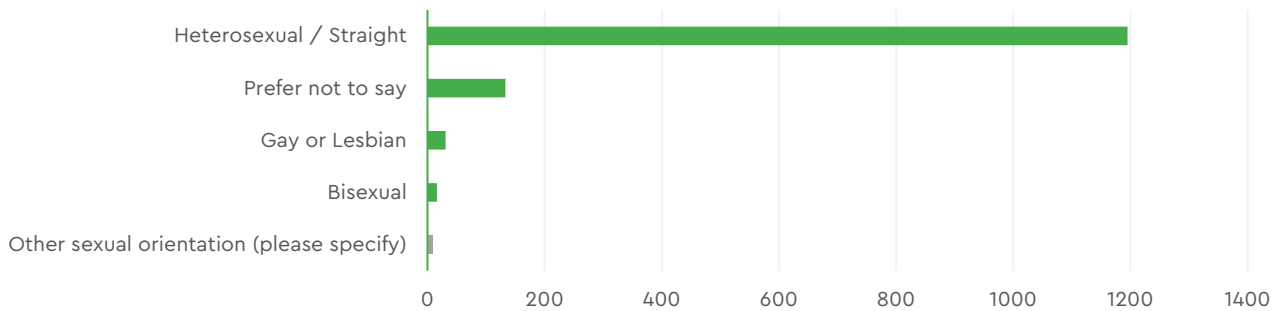
## Q55 What religion, religious denomination or body do you belong to, if any? (Please select one option)

Responses: 1230



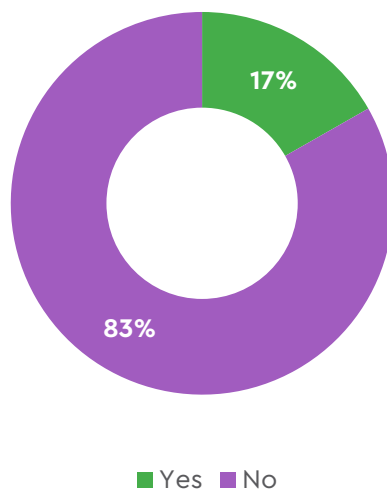
### Q56 What is your sexual orientation?

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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Report authored by

