SATA is a membership organisation with about 100 members. These include individuals, disability groups (e.g. Disability Access Panels, NFBUK etc.), local councils and transport operators (ranging from small groups with a couple of minibuses to East Coast).

SATA does not operate any transport services but aims to help its members to access the transport they need or in the case of providers to produce the transport required.

**Key themes**

The Committee is aware of the main issues which have been highlighted in previous studies. These are set out below, and the Committee is keen to move the debate on, identify the main priorities and really make a difference as a result of this inquiry.

1. **A lack of a strategic approach to community transport and the impact which a lack of transport has on people’s lives**

This really should be the last point not the first one. The answers to all the other questions given here and in other responses you have received emphasise the variability and lack of consistency in the operation of CT services.

We would agree with the analysis in the submission made by Ecas that there are two main issues – the split in responsibility (UK government, Scottish government, local authorities, NHS/Scottish Ambulance Service etc.) and the lack of co-ordination among providers.

Over the years there have been several surveys, investigations, conferences and seminars on this subject. But there has been no concerted action. CT services cover a wide range of different types of operation, so there is no need to delay action by piloting more schemes when we have tried and tested solutions. There is enough evidence and experience to develop and implement a Scottish strategy which would include management, operation and funding. Certainly it should encompass all the matters which are devolved to Scotland. All the issues such as volunteer/professional, charitable/commercial need to be resolved in a way which covers the whole range of the services, but still respects the autonomy, ethos and often the
charitable constitutions of the constituent organisations. We are not saying that there should be one controlling body for all CT services in the country, or even in one area, but that each organisation should be able to manage and develop its services having regard to its own specialisms and strengths, those of other operators in the field and particularly the needs and expectations of the end-users – individuals or communities. For instance, in the Lothians are the three largest CT organisations – LCTS, HcL and SEAG each deal with different community needs. In a more rural area one organisation may have to try to meet all the needs. The community, not the government or local authority, must be the arbiter of the needs of the community which the government or local authority must then facilitate.

2. **The growing demand for community transport provision**

The demand for community transport provision must be seen not simply in the context of a desire to travel but of the real need to travel – for work, services, recreation and sociability. In urban as well as rural areas there is a poor commercial bus service provision in many places, and the planners have presumed car availability. In these cases those without cars (the young, the old, the incapacitated and the poor) are all disadvantaged.

In addition services such as the Scottish Ambulance Service are no longer able to provide the service they once did, and the burden is falling on community transport which itself is struggling to meet the demand as lack of funding constrains purchase of vehicles and employment of staff.

SCVO has calculated that the third sector provides 2.6 million journeys a year in Scotland to those for whom no public transport exists or who are unable to use what does exist. For many of these, if they were not able to get out of the house using community transport, they would go into care homes at a possible cost to councils of up to £24k per year each.

3. **A lack of a coordinated approach with NHS bodies and community transport providers**

Many CT organisations have some degree of specialism, largely because of the way they grew up to meet a specific need in a specific place. And to some extent this determines the kind of vehicles which they operate. There would be scope for more liaison with NHS but this would only work well if some national strategy were in place for both operating and funding this kind of work.

4. **Eligibility criteria for non-emergency patient transport and the cost to NHS of taxi use.**
5. **Replacing community transport vehicles and funding planning.**

Most of the operators of community transport schemes will say that planning the funding of their operations is a major concern. Funding comes from a wide variety of sources – councils, government, trust funds, lottery grants and private donations. But it is all erratic, sporadic and haphazard. Operators are not able to plan more than a few months ahead (and often worry about how long they would survive if the funding dried up) because the sources from which they get their funds don't know how much they are going to have available. In some cases operators can get capital funds but not running costs, in others it is the reverse. Either way making any long-term plan is very difficult. It is exactly the same situation as the train operating companies faced with short franchises. These are now being replaced by longer franchises (10 to 20 years) – could we hope for the same in community transport, a longer term commitment to funding?

6. **Access to concessionary fares schemes.**

Many people, especially the disabled and aged especially in rural areas, are unable to use regular bus services either because they don't go to the right places, go at the wrong times or are physically inaccessible. Their only option is to pay to use a CT scheme. They are thus deprived of the free travel offered to others of their age and condition. The concessionary fares schemes should be applied to appropriate CT services.

**Scottish Accessible Transport Alliance**

**17 April 2013**