

Working together for better patient care



# Our Future Strategy Consultation Findings 2009



**NHS**  
SCOTLAND

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# Introduction

This report details the findings of the Scottish Ambulance Service's Future Strategy Consultation, which was carried out from January until September 2009.

In looking to develop the Service over the next five years, the Scottish Ambulance Service (SAS) sought the opinions of its many stakeholders across Scotland, including the public and patients, NHS Health Boards, GPs, voluntary organisations, the other emergency services, staff and the national partnership forum, MSPs and the Scottish Government.

These stakeholders have contributed valuable feedback and comment, which has ultimately informed the development of the SAS Strategic Framework, 'Working together for better patient care, 2010-15'.<sup>1</sup> Stakeholders have been supportive of the proposals put forward for discussion during the consultation. They have also brought several areas to our attention that require further consideration prior to any implementation.

## **Acknowledgements**

The Scottish Ambulance Service would like to thank the patients, staff and organisational stakeholders who gave generously of their time to provide feedback and to take part in discussion groups. Their views have been immensely important to the Service.

Thank you also to the Scottish Government Health Directorates and the Scottish Health Council for their valuable contribution to the SAS Strategy Development Project Board.

<sup>1</sup> 'Working together for better patient care, 2010-15' is available at [www.scottishambulance.com](http://www.scottishambulance.com)

# Glossary of terms

**A&E** – Accident and Emergency

**Algorithm** – an effective method for solving a problem using a finite sequence of instructions

**BASICS Scotland** – a Scottish organisation of medical professionals that assists the Scottish Ambulance Service as part of a co-ordinated response for patients

**Care Pathways** – the different routes by which patients can access healthcare

**Community Paramedic** – a more highly skilled paramedic working alongside other NHS colleagues to reduce unnecessary attendance at hospital

**CPR (Cardiopulmonary Resuscitation)** – a standard treatment for patients in cardiac arrest

**Defibrillator** – a machine which indicates whether a patient has had a heart attack and which can shock a patient's heart if necessary

**First Responder** – a trained volunteer working in local communities and able to provide immediate life support for a range of conditions

**NHSScotland** – National Health Service in Scotland

**NHS 24** – non emergency telephone service providing advice and access to healthcare

**Out of Hours** – healthcare which is provided outside of normal GP surgery times

**Primary Care** – providers of scheduled healthcare including GP surgeries

**PTS** – Patient Transport Service

**RRIG** – The Remote and Rural Implementation Group, a group chaired by NHS Highland, which has responsibility for leading the implementation of recommendations from the Scottish Government's report 'Delivering for Remote and Rural Healthcare', 2007

**SAS** – Scottish Ambulance Service

**Scheduled Care** – planned healthcare which operates on an appointment basis

**Skills Atrophy** – a decay in skills which arises when they cannot be used on a regular basis

**Triage** – an initial assessment of a patient's condition which determines their care needs

**Unscheduled Care Providers** – healthcare services which operate without appointment

## Consultation objectives

The need for a strategy which sets out the future direction of the SAS was identified as a result of the many significant changes in the Service in recent years and the Scottish Government's Strategy for NHSScotland, Better Health Better Care. From the outset it was anticipated that the Scottish Ambulance Service Strategy would see the Service align with this agenda for greater patient focus and improved partnership working for the development of the Service.

The objectives of the consultation were:

- To identify challenges and solutions to ensure that the service continuously improves its contribution to become more patient centred, more efficient and more effective.
- To have a two-way discussion with stakeholders about the key priority areas to inform the development of a vision and strategy for the Service.
- To raise awareness and understanding about the role of the Scottish Ambulance Service.
- To engage with staff about the purpose and values of the Scottish Ambulance Service.
- To develop opportunities for ongoing engagement and consultation with key stakeholders.

# Approach to consultation

## Topics for discussion

Four key priority areas were identified for discussion and are outlined as follows:

### ■ Getting help in an emergency

The Scottish Ambulance Service and NHS 24 have been asked by the Scottish Government to explore the development of a single clinical decision support tool to ensure that patients are appropriately routed to the care they need when accessing emergency services.

The consultation sought to test the level of support amongst patients and partners for this concept, to understand their needs in any new system and processes and to understand the challenges in ensuring its effective implementation.

### ■ Healthcare in remote and rural areas

The SAS has a lead role in collaborating with territorial NHS Boards to improve emergency response in remote and rural communities.

In support of this work, the consultation explored the needs around developing our current role, how we can involve communities better in the planning and delivery of services and how we can work better with partners to share resources for improved healthcare for remote and rural communities.

### ■ Getting patients to and from hospital

We believe there is an opportunity to improve the Patient Transport Service. In addition, we think there is potential to further develop specialised transport services for patients with specific needs, for example, those with heart or renal conditions or requiring end of life care.

The SAS will also play its part in the development of an integrated transport strategy for Scotland in partnership with the Scottish Government and other transport and healthcare providers.

The consultation looked at how we can work with our partners to improve the transport services we provide to patients with specific clinical needs and explored how we might adopt a collaborative approach to getting patients to and from hospital, which could also make use of non ambulance transport services.

### ■ Enhancing the care we provide

Current perceptions of the SAS are that our role is to respond in emergency situations to stabilise patients before transporting them to hospital. However, while this remains a primary function of the Service, we also work alongside our NHS colleagues on a number of other initiatives around the country. Many of these make use of the skills of our paramedics and other staff in some very different and innovative ways, with the aim of increasing the range of services available to patients locally within their communities.

We sought to gather information and opinion on how we can expand on this work to make a contribution to the wider healthcare agenda in Scotland.

### **Discussion document**

Key to the roll out of the consultation and engagement programme was the development of a discussion document covering each of the key discussion themes. Two versions of the document were produced, one for discussion with patients and a second version to prompt discussion with health partners and other public organisations. These documents clearly set out the current position of the SAS, the challenges and opportunities for the Service and the key questions for engagement with stakeholders.

### **Target stakeholders**

Over a period of nine months, the Service talked and listened to a wide range of stakeholders across the country including:

- Scottish Ambulance Service staff and Partnership
- NHS Health Boards, Regional Planning Groups, GPs, primary care providers and unscheduled care services
- Patient and public representatives and groups including community councils
- Community Health Partnerships
- The Scottish Government
- MSPs
- Community Planning Partnerships and Local Authorities
- Community Councils
- Voluntary Organisations
- Other Emergency Services

### **Quality**

In engaging with our stakeholders, the Service applied good practice in line with the National Standards for Community Engagement, staff governance and patient focus public involvement standards.

# Methodology and response

## Consultation and engagement plan

A comprehensive consultation and engagement plan was established to reach a wide range of stakeholders across Scotland, using a range of channels and formats.

The Plan split the consultation into two stages (1) an awareness raising stage and (2) the consultation stage. As the consultation developed, the consultation and engagement plan also developed. This resulted in the following activity:

### Awareness raising – January to June 2009

- A stakeholder awareness raising event in January 2009
- 28 awareness raising presentation and discussion sessions conducted nationally with NHS Boards, Community Health Partnerships, Patient Groups and Community Groups
- 5 promotional events in shopping centres in Aberdeen, Glasgow, Edinburgh, Inverness and Dundee
- Awareness raising presentation and discussion sessions with each of the 5 SAS Divisional Management Teams, including staff side representatives
- Awareness raising presentations with SAS National and Divisional Partnership Forums
- Awareness raising articles in the SAS staff bulletin, Response, in the Acting CEO's weekly bulletin to staff, on the staff intranet and on the SAS external website [www.scottishambulance.com](http://www.scottishambulance.com)
- An awareness raising email to an extensive range of external stakeholders, with a call to action to request a copy of the discussion document

## Consultation – June to September 2009

- Discussion document distributed as follows:
  - Emailed and mailed to 2122 stakeholder organisations. These emails also invited partner organisations to request a facilitated presentation and discussion
  - Distributed to over 1000 GP surgeries and health centres
- A total of 66 facilitated discussions and meetings
  - With a wide and diverse range of groups from the NHS Chief Executive's meeting to the Arbroath Thursday Club and geographically across Scotland
- Staff consultation
  - 15 facilitated Question & Answer sessions
  - Individual interviews with members of the Executive Team and Board of SAS
  - Discussion with SAS National and Divisional Partnership Forums
  - Discussion document published on website

### Supporting media plan

- Press – The Scotsman, local press
- Partner websites – Scottish Government, NHSScotland, Scottish Council for Voluntary Organisations, community organisations

### **Response channels**

To allow ease of response for participants, a range of response channels was established including email, mail, on-line forms on both the SAS external website and staff intranet and note taking at facilitated sessions.

### **Analysis of data and response**

The consultation produced only qualitative data and this was analysed internally by the members of the Project Team. To remove bias, the feedback for each of the key themes was analysed independently by three individuals and then brought together to determine convergent issues. The convergent issues have been used to form the basis of the findings.

The consultation resulted in 287 individual or organisational responses from external stakeholders.

This included responses from individual patients and external organisations including NHS Boards and associated groups, General Practitioners, health organisations, local authorities, community councils, the voluntary sector and the other emergency services.

The consultation produced a large number of responses from remote and rural sources. Due to the qualitative nature of the study, it has not been possible to quantify this completely, however it is important to note this fact.

# Findings and conclusions

## Getting help in an emergency

### 1. Accessing services

Some respondents have voiced concern that many people phone 999 unnecessarily because they are unsure about what to do in non-emergencies.

***“I did quite a lot of worrying before I rang, trying to decide whether it should be NHS 24 or the Ambulance Service.”*** Patient

Others have indicated that they are simply unaware of the phone number for NHS 24 altogether.

***“[The number] for NHS 24 is too long and there is a need for a smaller number the public can remember.”*** Patient

Health Board respondents were generally supportive of the concept to improve access, highlighting that streamlining access to healthcare could prove beneficial to patients.

***“Single points of entry... by their nature are easier for service users to access and for service providers to coordinate the required response.”*** NHS Lothian

However there was concern from some medical organisations that the concept could add to existing confusion.

***“[There is] evidence that the public are confused as to how they interface with acute medical care... this could possibly worsen the situation.”***  
College of Emergency Medicine

In scoping streamlined access to healthcare, there is also a requirement to consider the needs of minority communities with communication difficulties.

***“A system that is personally accessible for deaf people must also be set up in order that deaf people do not have to rely on TextRelay or family/friends/strangers to access emergency or out of hours healthcare.”***

Scottish Council on Deafness

Although a minor issue, it is important to note that some patients, who do not have a GP service available during Out of Hours, would still prefer to contact their GP as a first port of call, for example those in remote and rural communities and socially excluded patients.

***“Sometimes best to take a patient to GP, for example a socially excluded patient.”*** Patient

### 2. Single clinical decision support tool

The potential benefits in adopting a common approach to assessing patient needs were widely recognised.

***“A properly resourced common assessment system has the potential to ensure consistent assessment and appropriate care delivery.”***

British Heart Foundation, Scotland

Positive respondents, however, have also highlighted a number of practical issues, the importance of which must be considered if the use of such a tool is to be successful.

***“Concerns arise however with the use of computerised algorithms. These pathways cannot surpass human clinical decision making.”***

The Stroke Association

A few groups did express a concern that a system such as this could be more time consuming in practice and, consequently, self-defeating.

***“[We have]... reservations that this may add time to triaging of patients and delay an emergency response.”*** Perth Community Health Partnership

### 3. Increasing referral pathways

The SAS staff considered that a common triage system may enable more options regarding referral pathways if appropriate partnerships can be built up and relied upon.

***“Increased [patient referral] pathways should be available for falls, child protection, patients with mental health issues, patients with learning difficulties, and for alcohol abuse.”***

Paramedic, SAS

Staff have recommended improving practice specifically regarding mental health pathways. It was stated that the Accident & Emergency department is not the most appropriate place to take psychiatric patients and staff have also indicated the difficulty in accessing psychiatric services when specialist support is needed.

Several condition specific organisations have indicated their willingness to work in partnership to support the training and joint working infrastructure required around increased referral pathways.

***“We would ask that the SAS works with [us] in establishing and fulfilling the training needs of those carrying out such assessments of calls relating to epileptic seizures.”*** Epilepsy Scotland

However there was a minority view that a single framework may not be suitable for the wide range of services which would be required within an all encompassing common triage approach.

***“These cover a wide range of management structures, clinical approaches and service variations and will not easily fit within a single network.”*** NHS Fife

### 4. Co-ordination between agencies

Co-ordination between organisations is a concern for several respondents. Lack of communication between services has impacted negatively on many patients' experiences of the SAS in a number of areas.

Some patients highlighted the importance of matching the capabilities of the crew that is dispatched to the needs of the individual patient. They have indicated that technicians have sometimes been sent where paramedics were required. One health charity has suggested that the consequences of this can be particularly serious.

***“The ambulance arrived in 31 minutes and was manned by two ambulance technicians who [were not permitted to] administer the appropriate drugs... the technicians were very professional and angry that they could not have done more.”*** Patient

Co-ordination difficulties with Air Ambulances and Emergency Medical Dispatch Centre resources was also highlighted as an issue, particularly with regard to safe-landing areas and patient location.

***“I cannot fault the care received when the air ambulance arrived. However, members of my family have required this service 4 times within the last 2 years and on each occasion the wait was unacceptable, in one case over 4 hours.”***

Patient

### 5. Improved use of supporting technology

#### ■ Patient details available electronically

Consideration must be given to the systems and processes used to support a common triage approach. Respondents have indicated that eHealth initiatives such as a single transferable patient record are essential to the success of common triage, and that a consistency of approach across various agencies can be assured.

***“The continued development across Scotland of the emergency care record for every patient will be key to the creation of such a single point entry system.”*** NHS Lothian

Patients have indicated that they would support the use of a single-patient record that could be transferred alongside their calls, provided data security could be guaranteed. It is believed that this would prevent the need for patients to provide the same details to several different operators over the course of one phone call, as is currently the case, when transferred to different departments or organisations.

***“Obviously there is a need for some clinical records to be available beyond the GP surgery and given suitable safeguards regarding security of information, I can see no objection to this.”***

Patient

#### ■ National reporting

Health partners highlight the need for any new systems to be evidence-based and extractable for national reporting purposes.

***“An important aspect will be to ensure a single information system that uses common data standards and that allows data to be extracted for national reporting purposes.”*** NSS Scotland

## 6. National system with local application

Though most are supportive of the idea of a common triage system, a few Health Boards have expressed their apprehension over the applicability of such a scheme in their areas.

It has been suggested that there is a risk that a common assessment tool might duplicate the role of the Emergency Response Centre already established in NHS Lanarkshire, for example.

***“If single-assessment means centralisation of resources within a call centre, then local understanding can be lost and inappropriate referrals can result.”*** NHS Lanarkshire

Remote and rural users of NHS 24 have suggested that the national nature of the service has meant that local knowledge can be overlooked, and therefore assistance which is not relevant to their needs has sometimes been offered.

***“Local GPs here, unlike in towns, know what is wrong with most local people... NHS 24 and the 999 service cannot know the medical history of a person here so may provide an inappropriate solution to a particular problem.”***

Patient in remote and rural location

There are a few doubts over whether the proposed common triage tool would be equipped to meet responses in remote and rural areas. It is feared that this could result in a delay to an emergency response, in an area where responses might naturally take longer to begin with.

***“May be entirely impractical to the needs of island communities, where the GP has been the first point of contact for care.”*** NHS Western Isles

It has been pointed out that if the GP serving a remote and rural community is not made aware of an emergency call immediately, it can result in patients being taken to a hospital with no one to treat them. Some Health Boards for remote and rural communities consider that such calls may be better managed locally.

## 7. Efficiencies in Service

It is evident from consultation with staff of the SAS, that they consider that there could be global benefits in introducing a shared triage tool.

## Findings and conclusions

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***“Not only could such measures improve our patient focus, but they would be of additional benefit to us and NHS partners by reducing unnecessary use of ambulances and reducing pressures on A&E wards.”*** Paramedic, SAS

Relaxing current operational boundaries, geographically, could assist in providing greater access to care for patients.

***“To improve response, [we] should remove Emergency Medical Dispatch Centre control boundaries. Systems should be able to identify all SAS vehicles in all areas.”*** Employee, SAS EMDC

### 8. Partnership working

Many have also signalled a desire to see improved collaborative working with partners across the NHS. It has been stated that primary, acute and emergency care is currently “fragmented”. It is believed that a more integrated service could help to improve delivery of care, as it is currently felt there is an inconsistency in approach across different NHS services. Additionally, improved partner relations may enable NHSScotland to work more efficiently to improve access for patients as resources could potentially be shared.

***“There does not seem to be any integration between the various services or departments to minimise unnecessary journeys.”***

Lochgail Community Trust

In addition to closer integration with NHS services, many SAS staff have stated that they feel relations could be improved with other external agencies, with a view to enhancing care for patients. This view is mirrored by external agencies who are aware of the potential benefits in a tailored approach, appropriate to patients’ needs.

***“We are very keen to work with the SAS and its partners on identifying possible training needs and helping to develop a new care pathway for seizures.”*** Epilepsy Scotland

### 9. Training and development

Call handlers would require additional training in order to ensure consistency of service and to appropriately refer patients along the various referral pathways to care.

It is essential that staff are both capable and confident in dealing with a range of health issues. Currently, many call handlers have little or no clinical background so any changes would require significant investment in staff development.

***“Those who take calls must be confident and competent enough to refer patients along the appropriate pathways.”*** Employee, SAS

For example, there is a desire for an improvement in accessing psychiatric care and suicide prevention training.

***“Ambulance staff are often the first point of call from the public when someone is identified as being suicidal.”*** Health Scotland

### 10. Public engagement

Respondents consider that a changed system for emergency and non-emergency care requires widespread public engagement.

***“There is a risk that if patients dial 999 and are transferred between services (i.e. from 999 to NHS 24) then they will take the path of least resistance.”*** NHS Tayside

This suggests that engagement is not only essential to educate the public about how to potentially access a range of healthcare services, but to give assurance that they will receive emergency care as swiftly as they could reasonably expect by dialing 999.

## Conclusions

### Accessing the right help in an emergency

The concepts for improving access and clinical decision support were favourably received. Partner organisations consider that this approach could prove beneficial for patients. The feedback received has confirmed our thinking around the considerations and challenges involved in scoping and specifying an improved approach and supporting decision making tool and also presented some new issues for our consideration:

#### 1. Accessing Services

- There is some confusion amongst patients about how and when it is appropriate to contact 999 and NHS 24
- Some patients have indicated they are unaware of the NHS 24 number and suggested the need for a shorter number
- The access needs of those patients with communications difficulties, for example, the deaf community, must be taken into account in scoping improved access to healthcare
- There is a minor view that the suggested approach could result in more confusion, rather than present a solution to existing problems
- A small number of patients in remote and rural locations have indicated a preference to contact their GP out of hours, rather than the centralised system

#### 2. Single clinical decision support tool

The potential benefits in adopting a common approach to assessing patient needs were widely recognised, including the potential to ensure consistent assessment and appropriate care delivery. However a number of important practical issues must be considered if the use of such a tool is to be successful, including:

- Computerised algorithms cannot surpass human clinical decision making
- This approach may add time to triaging patients and delay an emergency response
- Co-ordination between services internally with the SAS (Air Ambulance and Emergency Medical Dispatch Centres) and services externally are crucial to the success of any improved approach
- There is a need to ensure that the capabilities of the responding crew are matched to the needs of patients
- Access to a single transferable patient record is essential to ensure consistency of approach across various agencies
- The system should be evidence-based and extractable for national reporting purposes
- There is a risk that a common assessment tool might duplicate the role of the Emergency Response Centre already established in some areas
- A national approach must not overlook the need for regional and local knowledge – this is particularly important in remote and rural areas
- Relaxing current operational boundaries, to enable an ambulance to respond outwith its dedicated area, could assist in providing greater access to care for patients and more flexible use of resources

## Findings and conclusions

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### 3. Increasing referral pathways

- Increased referral pathways should include pathways for falls, child protection, epileptic seizures, mental health issues, learning difficulties and for alcohol abuse
- There is an inconsistency in the availability of referral pathways available in NHS areas geographically
- There is a minority view that a single framework may be difficult to achieve and manage because of the wide range of services that would be required to link with the common approach

### 4. Partnership working

- NHS partners have signaled a desire to work collaboratively to develop and implement a common decision support tool, indicating that there could be global benefits for patients and for efficiencies across NHSScotland – reducing unnecessary trips to hospital, reducing unnecessary use of ambulances and reducing pressures on Accident & Emergency wards
- Appropriate current knowledge, training and skills gained elsewhere in the NHS should be used to inform the development and implementation of the improved approach
- Other voluntary and public sector partners have also indicated a willingness to work in partnership to improve access to specialised services for patients

### 5. Training and development

- Improved systems and processes and increased referral pathways will require a common approach to training and development of call handlers and other staff involved across the full range of services, to ensure consistency of service
- A comprehensive programme of training will also ensure knowledge of increased referral pathways and that staff are confident and competent to refer patients along appropriate pathways
- There has been a specific request from SAS staff for suicide prevention training

### 6. Public education and engagement

- An improved approach for accessing emergency and non-emergency care will require widespread public education and engagement:
  - to ensure that the public and patients have clarity around when to call for emergency help and when to call for non-emergency help
  - to ensure that the public and patients know which numbers to call in emergency (999) and non-emergency situations (NHS 24)

## Healthcare in remote and rural areas

### 1. Improving healthcare for remote and rural communities

Respondents for remote and rural communities have been largely supportive of the stated proposals from the Remote and Rural Implementation Group (RRIG) for a range of optional models which can be tailored appropriately for communities to improve the delivery of healthcare in their areas.

***“We are delighted to see the emphasis on remote and rural healthcare in the SAS strategy.”***  
NHS Highland

Community partnerships have also largely welcomed the proposed models for improvement:

***“We like the comment [made in the SAS discussion document] ‘one size does not fit the whole of the NHS’.”***  
North Highland Community Health Partnership

Key medical organisations are also in favour of the proposals:

***“These possible models of care provide a flexible emergency response system which can be tailored appropriately for communities.”***  
The British Medical Association (BMA)

### 2. Getting help in an emergency

Some patients in remote and rural locations have expressed a lack of faith in the levels of information held by NHS 24 about the services in their locale and have indicated that call handling staff need more information about geographical areas, distances and the locations of healthcare facilities.

There are also some concerns about air ambulances being called out for non urgent cases as cover on the ground is not available.

A small, but significant number of respondents noted that the previous system where GPs were on call, out of hours, worked best for them.

Patients in remote and rural communities currently indicate a lack of confidence that their emergency health needs will be met and that responses will be swift. Several have expressed concern about the lack of resources available to remote and rural patients, especially in the Highlands and Islands.

***“We feel extremely vulnerable and cut off after 6pm, the last ferry crossing in autumn, winter and spring.”*** Patient, Isle of Luing, Argyll

### 3. First responders

The First Responder Scheme has been received well and there are opportunities for development.

***“[We] welcome first responders and [we] should make use of other emergency service staff who have vehicle priority.”***  
The Highland Senior Citizens Network

Several respondents have raised the possibility of increasing the involvement of BASICS Scotland GPs and nurses as first responders in an emergency.

***“Deployment of BASICS GPs and nurses has been very limited.”***  
Remote Practitioners Association of Scotland

Similarly it has been suggested that there could be a greater involvement of British Red Cross and other voluntary agencies in delivering first response and in offering post-hospital care in remote and rural communities.

## Findings and conclusions

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Some respondents did stress that using local volunteers to provide life support should not be used to replace a response by the SAS.

***“This should not be a reason for SAS response to be diminished or delayed in any way.”***

Rhu and Shandon Community Council

### 4. Referral pathways

A large range of referral pathways are not always available to residents of remote and rural communities and there is some unease from patients around accessing specialist help quickly enough. Local issues include the difficulty of providing access to mental health care, the ease of providing escorts when required on the Isles and the use of ferries to transport suicidal patients.

***“...sectioned patients can be waiting in excess of 24 hours to be transferred.”***

NHS Western Isles

The need to train SAS staff in suicide prevention has been raised as an issue.

***“Training in suicide prevention is especially important in remote and rural areas where other services are not as numerous.”***

Health Scotland

### 5. Developing community engagement and resilience

Working with communities to foster a collective responsibility for healthcare is fundamental to the success of delivering improved healthcare for remote and rural communities.

***“It is vital that ambulance services are complemented with a network of GPs and trained volunteer first responders, public access defibrillators and an increased proportion of the population able to provide emergency life support.”***

British Heart Foundation Scotland

One respondent has stated that “historical boundaries and current ways of working will need to be challenged”.

Respondents have stated that community engagement and co-ordinated planning is necessary.

***“The SAS and Health Boards need to jointly and comprehensively involve the public in the planning and delivery of service.”*** NHS Highland

***“Patients, and their community representatives, still do not feel sufficiently involved in the design and delivery of services.”*** MSP, Orkney

Respondents have signalled the need for training and development opportunities for communities to be all inclusive, ensuring the involvement of minority groups as well as the wider community.

Many patients and patient-centred organisations acknowledge that working collaboratively and using the skills of Ambulance Service personnel to provide additional services, would be very valuable to remote areas, where accessing healthcare is not as straightforward as going to hospital for an appointment.

***“It is important to utilise available enhanced skills of SAS personnel for maximum effect on patient care and the use of overall NHS resource.”***

NHS Tayside

There would be benefits in a joint approach for all involved, including SAS staff, who currently experience skills atrophy in some areas.

***“Skills atrophy is the biggest drain in rural areas and would be beneficial if staff worked with GPs and other healthcare staff.”***

Paramedic, the SAS

Patients have indicated that they would be receptive to a visit from an appropriately skilled Paramedic or Technician to treat them at home for minor injuries or illnesses or to manage long term conditions.

***“Treatment at home for long term conditions is welcomed and will demand close liaison with... Primary Care Trusts and hospital units.”***

Highland Senior Citizens Network

Support has been expressed for use of community paramedics in remote and rural communities, as well as the SAS taking a proactive role in helping to provide preventative care in these areas.

In expanding roles, there is a minor view that the SAS would be duplicating services already available through other channels.

***“In some instances... you might tread on the toes of the district nurse.”***

Highland Senior Citizens Network

NHS partners have indicated many opportunities for sharing resources, including premises and vehicles to facilitate the move to an integrated solution.

***“There is definite merit in exploring joint premises at hospitals and health centres to provide more uniform coverage.”*** GP, Ayrshire

***“The Council would be eager to work with the SAS to further develop the concept of multi-purpose vehicles that can be used for other health and social aims.”*** Orkney Islands Council

As a final point, NHS Lothian has recommended that models of care should not be isolated to remote and rural communities.

***“There is a need to build on the innovation that is being developed in remote and rural areas and look to introduce them into urban areas.”***

NHS Lothian

## **6. Getting patients to and from hospital**

Respondents in remote and rural communities have suggested that they cannot rely on public transport to take them to and from hospital because there are few options available.

Transport for those people who do not have a direct clinical need, but do have a social or geographic need, is an issue. While it may be easier to refer people, who do not qualify on clinical grounds, to an alternative provider in urban areas, this is problematic in remote and rural areas, where the same range of alternative transport providers is not available.

## Findings and conclusions

It has been suggested that a lack of co-ordination between services can result in long waits for treatment and transfer.

***“Geographically there is no co-ordination of appointments in rural areas.”***

North & West Sutherland Community Care Forum

PTS crews in the North can feel especially pressured due to long journeys to and from the central belt.

There are also reports of specific problems for patients discharged from hospital, who although pronounced fit for travel by the hospital, were unable to secure appropriate transport and had to endure long journeys home by public transport.

***“[I] had to get service bus from Aberdeen to Lochinver after a 5 hour operation.”*** Patient

### 7. Managing expectations

It is vital to the successful introduction of new models of care that public expectation of the services which can be provided by the Scottish Ambulance Service is effectively managed.

***“There needs to be clarity with regard to the role and remit and clarity on the expectations from the service and the public.”*** NHS Tayside

It has been suggested that these models of care have the potential to be perceived as cost-cutting measures. Similarly, one respondent considers that government targets have redirected resources from rural areas into urban zones. Some respondents have stated that NHS Health Boards should be the drivers for addressing access problems in Remote and Rural areas instead of the SAS. Thus, the relationships between Health Boards and SAS are critical to the success of delivering remote and rural healthcare.

## Conclusions

### Delivering for remote and rural healthcare

Respondents are extremely supportive of the stated proposals for a range of optional models, which have resulted from the work of the Remote and Rural Implementation Group and which can be tailored to community needs to improve the delivery of healthcare in their areas.

#### 1. Improving healthcare for remote and rural communities

- Respondents are pleased that the SAS recognises that ‘one size does not fit the whole of the NHS’ and that services may need a different configuration in different areas

#### 2. Getting help in an emergency

- Patients in remote and rural communities currently indicate a lack of confidence that their emergency health needs will be met and that responses will be swift
- Information currently held by NHS 24 about geographical areas, distances and the locations of healthcare facilities in remote and rural locations needs to be improved
- New approaches must consider the appropriate use of resources, for example, air ambulance reserved for emergency use and appropriate resources on the ground for non-emergency cases
- A small number of respondents stated that GPs on call during out of hours works best for remote and rural communities

### 3. First responders

- The First Responder Scheme has been received well and there are opportunities for development
- The SAS should consider increasing the involvement of BASICS Scotland GPs and nurses as first responders
- The SAS should consider a greater involvement of the British Red Cross and other voluntary agencies in delivering first response
- The SAS must continue the practice of using volunteers as an additional resource to provide life support in the first instance and must not allow volunteers to replace a response by the SAS

### 4. Referral pathways

- A wide range of referral pathways is not always available in remote and rural locations
- Patients are concerned about accessing specialist help quickly enough
- Of great concern is the difficulty in accessing emergency psychiatric care specifically and there is a suggestion to train SAS staff in suicide prevention techniques to help in this area

### 5. Developing community engagement and resilience

- Working with communities to foster a collective responsibility for healthcare is fundamental to the success of improved healthcare for remote and rural communities
- Historical boundaries and current ways of working will need to be challenged

- The SAS and NHS health boards need to involve the public in planning and delivering services
  - Healthcare training and development for communities needs to be inclusive, ensuring the involvement of minority communities
- Using the skills of Ambulance Service personnel to provide additional services would be very valuable for remote areas, where accessing healthcare is not as straightforward as going to hospital for an appointment
  - There would be benefits for all agencies involved, reducing skills atrophy
  - Patients would be receptive to a visit from appropriately skilled SAS staff to treat them at home for minor injuries or illnesses or to manage long term conditions
  - There is also support for community paramedics and a proactive role for the SAS in helping to provide preventative care
  - There is a minor view that the SAS would be duplicating services already available through other channels
- Partners have indicated many opportunities for sharing resources including premises and vehicles to move towards an integrated solution
- RRIG models of care should not be restricted to remote and rural communities. This innovation can be tailored for urban city areas also

## **6. Getting patients to and from hospital**

- Patients in remote and rural communities do not have a wide range of public transport options available to them
- As a result referral to alternative providers is problematic for those people who do not have a clinical need for transport, but do have a social or geographic need
- Respondents also state that there is a lack of co-ordination currently between services, resulting in long waits for transfer or treatment
- There are currently some specific problems for patients discharged from hospital who sometimes have to endure long journeys home by public transport

## **7. Managing expectations**

- It is vital to the successful introduction of new models of care that public expectations of the services that can be provided are managed carefully
- There is a potential for the introduction of these new models to be perceived as cost cutting measures, rather than as intended improvements to healthcare services
- Good working relationships between NHS Boards and the SAS will be critical to successful introduction

## Getting patients to and from hospital

### 1. Improving the Patient Transport Service

The majority of respondents have indicated that improvements are required to the current Patient Transport Service.

***“The current booking system is not working well.”***  
SAS Staff Member, Area Service Office

Patients have informed us that they often have difficulty arranging transport.

***“[I] could not get hold of PTS to arrange transport for 3 days [and I] finally arranged this 1 business day before my appointment.”*** Patient

### 2. Assessing patient need

There is a lack of clarity about who is entitled to transport. It is widely agreed by the majority of stakeholders that the current eligibility criteria for the PTS require to be reviewed. However, while some have explicitly stated support for assessing eligibility for the PTS according to clinical need, others have reservations about whether this should be the only determining factor.

***“More information needs to be provided to public and agencies to see who qualifies for transport.”*** Patient

Several respondents across the broad range of stakeholders indicate that they consider the PTS should be for patients with a clinical need and that those who do not have a clinical need should be referred to alternative transport providers.

***“Transport by ambulance should be based on clinical need assessed by GP/hospital. SAS should not be involved in alternative arrangements which should be devolved to Social Work Departments.”***

Rhu and Shandon Community Council

Several NHS Boards have stated that they would like to see alternatives to ambulance transfer where patients do not require the skills and equipment of the PTS. They have suggested that resources could be better directed towards supporting alternative arrangements.

***“Social and geographical factors can be significant constraints to patients... and as such better use requires to be made of the non-NHS provided transport options that are available.”***  
NHS Lothian

However, despite support for a clinical need criterion, an equal number of respondents expressed that a “safety net” was required for certain patient groups.

***“PTS should account for those who cannot afford to reach hospital by other means, or who may struggle mentally and emotionally as well as physically.”*** Highland Senior Citizens Network

### 3. Planning and co-ordinating journeys

Several regular users of the PTS informed us that there is sometimes a lack of co-ordination of PTS journeys, for example, making multiple journeys for individual patients where one pick-up of several patients may be more appropriate.

***“There does not seem to be any integration between the various services or departments to minimise unnecessary journeys.”*** Patient

On occasion, the crew and ambulance dispatched do not fully meet patients' needs.

## Findings and conclusions:

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***“Three out of five regular PTS journeys have been with single crew when double-crew is required due to patient condition.”*** Patient

SAS staff consider that sometimes PTS bookings taken from doctors are made too far in advance and that there is little or no accountability for misuse where senior clinical staff make PTS arrangements.

#### 4. Partnership working

The majority of respondents advocate closer working with partners and voluntary organisations for an integrated transport solution. Many have indicated that they consider the PTS could benefit from working in tandem with bus companies or charitable services.

***“Would welcome joint working with other agencies to provide transport for people with social and medical needs.”*** Patient

Working with partners such as GPs to help co-ordinate appointments and clarify exactly when arranging PTS is appropriate could help improve the service.

Several respondents have suggested that the PTS could benefit from closer co-ordination with acute hospitals, particularly with regard to the scheduling of outpatient appointments. This is a particular concern in remote and rural areas.

***“There is no co-ordination of appointments to take into account the huge distances that need to be travelled. Raigmore is two hours plus one way. Therefore a return journey to attend an essential medical appointment can take around five hours.”*** Patient

Patients who require PTS could benefit from such schemes if reliability could be assured.

***“Volunteer and charitable alternatives are cheap and appreciated, but service is often erratic. SAS should be more involved in planning service.”*** Patient in remote and rural location

***“The improved engagement of local authorities through regional transport partnerships will be a key part of achieving success.”***

The West of Scotland Regional Planning Group

One group has raised the question of whether patients would be liable for costs if alternatives are to be used.

In areas where it is difficult for patients to get to hospital, it is essential that the PTS criteria accounts for regional idiosyncrasies and considers the potential of this, many health boards have recommended close partnership working in designing PTS criteria.

Concerns are particularly pertinent where patients may be discharged in the middle of the night. Therefore, support is required for those who do not meet clinical need criteria, but whose task of getting to and from hospital presents a problem in itself. This also includes patients on low income who cannot readily afford private transport, and for whom public transport may not always be appropriate, depending on their condition.

***“PTS operates 9-5, what about patients discharged in middle of night?”*** Patient

Attention is also drawn to the problems experienced within Health Boards as a result of patients experiencing difficulties in getting to hospital:

***“Failings within the current PTS have a significant impact on the management of waiting times when appointments have to be cancelled or patients Do Not Attend as a result of being unable to reorganise their transport.”***

NHS Highland

Support for condition specific services is mixed. In some instances there are clear benefits to providing a condition specific service.

***“[We] agree that renal transport is excellent, the driver has knowledge of condition.”***

Patient

SAS staff are aware of the benefits condition specific services can provide for patients and there is a desire among them for equally well managed services to be increased.

***“Need for Ambulance Care Assistants (ACA) to have more knowledge on patients’ conditions. Better communication is needed between GP/hospital and ACAs.”*** ACA, SAS

However, some NHS Boards warn against over-specialisation in terms of providing transport to patients with specific needs, which risks the “creation of unaffordable infrastructure or requirements for new types of resources.”

There is a desire for the government to take a stronger role in advocating joint planning for transport.

***“Need to maximise the use of ALL publicly funded transport.”***

Durness Community Care Forum

Several NHS Boards have expressed concerns about the efficiency of the Inter-Hospital Transfer Service and SAS staff have raised concern that this is an area of growing activity.

## 5. Extending the Service

In addition to the need for improvement, there are also requests, as a result of increased hours of operation across NHSScotland, to extend the hours of the PTS.

***“As a consequence of the increasing number of evening and weekend services within the NHS, there is a growing need to extend the provision of non-emergency transport.”***

NHS Lanarkshire, Occupational Therapy Department

It has been questioned why the PTS should only operate at certain times, to take patients to and from hospital, when it could equally be used to take patients to out of hours clinics.

There has also been a suggestion that the PTS could be used to facilitate GP or day care centre appointments.

***“Access to hospital is only one purpose for which healthcare transport is required, people also need to attend their GP, optician, chiropodist, day care centre etc.”*** NHS Highland

## 6. Public education and engagement

As indicated, there is confusion over who qualifies for Patient Transport Services and this extends to a confusion amongst the public about the other transport options that may be available.

*“I know Red Cross does things too, but who does what and how one can get help is a mystery.”* Patient

One patient group has expressed an additional concern that patients are not currently utilising their mobility allowance for disabled taxis. Patients are not fully aware of their options, rights and responsibilities in relation to healthcare transport, including the availability of the hospital travel scheme funding.

*“People should be using their mobility allowance for disabled taxis.”* Patient

There is a concern amongst staff that, not only is the public unsure of the criteria for accessing PTS, but NHS staff, such as GPs, are not always using the service appropriately either.

Improved partnership working, where all parties are clear on their roles and convey a consistent message, would bring benefits and respondents consider that the SAS has a responsibility to publicise and clarify the service.

## Conclusions

### Getting patients to and from hospital

The need to improve the current Patient Transport Service is a recurrent theme throughout the consultation.

#### 1. Improving the Patient Transport Service

- The current system for booking is confused between agencies and is not working as well as it should
- Patients sometimes have difficulty arranging transport

#### 2. Assessing patient need

- There is a lack of clarity about who is entitled to transport
- It is widely agreed by the majority of stakeholders that the current eligibility criteria for the PTS require to be reviewed and partners are keen that this is done in partnership
- The majority of respondents consider the PTS should be for patients with a clinical need and that those who do not have a clinical need should be referred to alternative transport providers
- A significant group consider that PTS should also cater for those who may struggle socially, geographically, mentally and emotionally as well as physically or who cannot afford to reach hospital by other means

### 3. Planning and co-ordinating journeys

- There is sometimes a lack of co-ordination of PTS journeys, resulting in multiple journeys for individual patients, rather than co-ordinated pick ups of several patients
- Current procedures for booking can result in 'misuse' of the system and confusion for patients
- Booking systems need to be streamlined and criteria applied consistently
- The SAS needs to govern application and interpretation of criteria across agencies and manage expectations
- Dispatched vehicles and crews are sometimes not resourced adequately to meet patients needs
- PTS booking and planning would benefit from greater co-ordination with hospitals, in particular with out patient departments
- This is especially important when dealing with long journeys to hospital in remote and rural areas

### 4. Partnership working

- There is a 'pressing' need for joint working with other agencies to provide alternative transport for people who do not qualify for the PTS – part of an integrated transport solution
- There is a desire from partners to explore the possibility of sharing PTS and Community Transport vehicles
- Respondents in remote and rural communities cannot rely on public transport to take them to and from hospital and an integrated transport solution must consider their needs
- Failings in the operation of the current PTS have a significant impact on the management of waiting times, when appointments have to be cancelled or patients do not attend because they are unable to reorganise their transport

- In developing a clinically focused scheduled service, there will be a need to ensure staff are fully trained
- There are concerns about the co-ordination of services for patient transport after discharge from hospital, especially in remote and rural areas where patients are deemed fit to travel, but may have to endure long journeys on public transport
- There is a need to develop and improve the Inter Hospital Transfer Service in the context of increasing activity and expectations in this area
- The role of transport co-ordinator is welcomed, however there is a risk of increasing bureaucracy without enhancing service. This role needs to be more visible

### 5. Extending the service

- There are requests, as a result of increased hours of operation across NHSScotland, to extend the hours of the PTS
- There are also requests to make transport available for patients who have a non-hospital appointment, for example with a GP or Optician

### 6. Public education and engagement

- Any revised criteria would require clear and concise publicity to ensure clarity with patients and partners
- There is a concern that patients do not know to use their mobility allowance for taxis
- There is a concern that patients are not aware of, or are not using, hospital travel scheme funding

## Enhancing the care we provide

### 1. Extending the SAS contribution to NHSScotland

Respondents were mixed in their support for the concept of SAS staff working in extended roles to contribute to the delivery of primary care services. There are many good examples of this work already occurring in pilots across the country, and these are impacting positively on unnecessary hospital admissions. Where this is the case, partner organisations are keen to see the work and role of the SAS extended.

***“As is evidenced over the last few years, there is benefit to the SAS further developing the skills and competencies of its workforce to extend the scope of the service it currently provides.”***

NHS Greater Glasgow & Clyde

The majority of partners have recognised potential benefits to enhancing our contribution to healthcare, however, some remain uncertain about how this could be achieved and have expressed concern about how this could impact on existing services.

***“While we note SAS’s aspirations re providing enhanced care, we feel that it is essential that core services are the first priority, before diversification can occur.”***

Aberdeenshire Community Health Partnership

The issues surrounding these two points of view are presented in more detail as follows:

### 2. In support: benefit to patients

Many patients have indicated support for treatment at home to avoid unnecessary trips to hospital.

***“I would be happy to be treated in my home by a paramedic as long as they had the right qualifications.”*** Patient

Many health boards have cited evidence that there is benefit to extending the scope of their services.

***“Particularly during Out Of Hours, when it is in the patient’s interest to avoid unnecessary admission to hospital.”*** NHS Lothian

***“[This work has] reduced the amount of time wasted previously by ringing the various telephone numbers to organise and co-ordinate admission.”***

West of Scotland Regional Planning Group

Of those who responded positively, a majority saw particular benefit to the SAS providing non-emergency treatment in remote and rural communities, where access to practitioners is not always straightforward and trips to hospital can be arduous and time-consuming. Several have welcomed the idea of providing out of hours home visits to deliver care, performing roles which have traditionally been the reserve of the local GPs.

***“GPs are now unavailable for emergency response in remote rural areas”.*** Patient

Support has also been expressed for use of community paramedics in remote and rural communities, as well as the SAS taking a proactive role in providing preventative care in these areas.

***“Treatment at home for long term conditions is welcomed and will demand close liaison with... Primary Care Trusts and hospital units.”***

Highland Senior Citizens Network

One of the challenges stated will be the ability to create and maintain clear and consistent boundaries between SAS staff and other healthcare professionals to ensure that all involved can work together to provide added value for patients. Effective partnership working would be essential to the success of any programme of delivering primary care.

***“There could be an opportunity to develop SAS personnel to work with advanced nurse practitioners in emergency paediatric practice.”***

The Royal College of Paediatric and Child Health

Continuous evaluation and auditing has also been acknowledged as vital to ensuring that enhanced care is both efficient and effective. With such measures in place, expectations can be managed better and allow an evidence base for both SAS and partners to develop and refine the roles for improved and sustainable working relationships.

Some respondents considered that the best way to achieve enhanced care would be via the provision of a mobile clinic.

***“Bringing services to the public rather than the other way around.”*** Patient

It will be vital to ensure that SAS staff have the right skills and capabilities to deliver extended services and some partners have indicated that they would welcome provision of additional help in areas of mental health and dementia, specifically.

### **3. In opposition: improve core services**

As indicated, some respondents have expressed reservations about the impact that extending services could have on the ‘core business’ of the SAS.

***“We are keen to work in collaboration with the SAS to see the effective delivery of its core role before exploring how resources might be diversified into other areas.”*** NHS Highland

It should be noted that there is support for the positive aspirations of the Service, but that it should not be a priority at this time.

***“We recognise and support many of the aspirations... we would recommend that the SAS’s priority must be to ensure that its primary role as a provider of an emergency response service is met in full.”*** The British Medical Association

A minority of patients have stated that they would support provision of primary care, provided emergency response was not compromised. Others indicate that they are not satisfied that emergency care provision is at a sufficient standard for SAS to consider expanding its roles.

***“The Community Council is of the view that medical care in the home should continue to be delivered by doctors, nurses and midwives.”***

Sleat Community Council

There was some concern around adequate funding and availability of resources for extended services. It is felt that by offering an extended service, the SAS could be “spreading itself too thin.”

Some respondents consider that by diversifying the roles of SAS, we would effectively be duplicating a number of NHSScotland services. One respondent has suggested we may “tread on the toes of the district nurse.”

## Conclusions

### Enhancing the care we provide

Respondents were mixed in their support for the concept of SAS staff working in extended roles to contribute to the delivery of primary care services.

#### 1. Extending the SAS contribution to NHSScotland

- Some partners are positive about the idea of ambulance service staff working in extended roles to support primary care
- Some partners remain uncertain about how this can be achieved and how this could potentially impact on other services

#### 2. In support: benefit to patients

- Many patients would welcome treatment at home where it was appropriate
- There is evidence from current work that using SAS staff in extended roles has a positive impact on reducing unnecessary hospital admissions
- This works particularly well during out of hours, when it is in the patient's interest to avoid unnecessary admission to hospital
- There could be particular benefit in extending services into non-emergency treatment in remote and rural communities
- The suggestion of providing out of hours home visits in remote and rural communities has been welcomed
- Effective partnership working would be essential to the success of any programme of delivering primary care
- Clear and consistent boundaries with other healthcare professionals will be necessary to ensure a joined up approach with added value for patients

- Continuous evaluation and auditing will be vital to ensure enhanced services are effective
- Consideration should be given to the provision of a mobile clinic service
- Several partners would welcome additional services from the SAS in the areas of mental health and dementia
- It will be vital to ensure that staff have the right skills and capabilities to deliver extended services

#### 3. In opposition: improve core services

- There is support for the positive aspirations of the Service, but this should not be a priority at this time
- There are reservations about the negative impact extended services could have on the 'core business' of the SAS
- Emergency response should not be compromised
- Some respondents are not satisfied that emergency care is at a sufficient standard to allow consideration of extended services
- There is some concern around adequate funding and the appropriate allocation of resources to offer extended services. A concern that the SAS could be 'spreading itself too thin'
- Some considered that diversifying the roles of SAS staff could be duplicating a number of existing NHSScotland services

# Recommendations

## Getting help in an emergency

### 1. Accessing services

There is a need to ensure clear education and guidance for the public and patients around entry points for accessing healthcare.

- This must make certain that there is clarity for the public around what is an emergency, what is not an emergency and the appropriate access routes to use
- Consideration should be given to the introduction of a number which is easier to remember for non-emergency calls – a number which can get into the public psyche in the same way as 999
- Clarity of processes and ease of access to healthcare for patients with communication difficulties is required, supporting the use of assistive technologies where possible

### 2. Single clinical decision support tool

The benefits of a single clinical decision support tool in ensuring consistency of approach to patient triage appear to be largely understood, particularly by healthcare partners. The original thinking in how to move forward with the scoping and implementation of a tool has been largely confirmed:

- We need to work with partners to build a clear specification for the tool
- We must consider that a computerised algorithm cannot fully replace human clinical decision making
- Consistency of approach and common processes across all user organisations will be paramount to its success
- Co-ordination between services will be crucial to enable matching of available resources and skills to patients needs

- Access to a single transferable patient record will ensure that patient details are recorded once and then can be transferred across the system to the appropriate agencies involved in the 'patient's journey'
- The tool must allow for consistency at a national level, but importantly, must allow for effective application at a local level
- Any new system must be evidence based and data must be extractable for national reporting
- Specifically for the SAS, consideration should be given to the relaxation of local geographical boundaries, to allow allocation of appropriate resources to meet demand

### 3. Referral pathways

- Additional referral pathways available within the system will ensure that responses can be more appropriately tailored to patient healthcare needs

### 4. Partnership working

- Working in partnership with NHS partners and other key public and voluntary sector partners, to develop crucial patient referral pathways and specify requirements, develop and implement the new system and its associated processes will be crucial to securing the anticipated global benefits to patients
- Public and patient involvement in developing and implementing processes and the new system is required to ensure a patient-centred approach
- This will require the SAS to take a good quality strategic approach to patient and partner engagement and relationship building

## 5. Training and development

- A common and comprehensive training programme for all involved in implementing the approach/system will ensure consistency of service and standards for the patient
- Training must also ensure that staff have knowledge of and are confident and competent to refer patients along appropriate pathways, for example, increased knowledge of mental health pathways and suicide prevention training
- Where appropriate current knowledge, skills and training gained elsewhere in the NHS must be shared as part of the process

## Healthcare in remote and rural areas

### 1. Improving healthcare for remote and rural communities

- The consultation has found that the Remote Rural Implementation Group proposals for a range of optional models for healthcare have been positively received. The SAS must now capitalise on this momentum to ensure positive and effective implementation of the models.

### 2. Getting help in an emergency

- The SAS must work to facilitate and help develop a sense of confidence amongst remote and rural communities, that their emergency health needs will be responded to quickly
- Information held by central healthcare agencies, including the SAS and NHS 24, must ensure a detailed knowledge of geographical areas, distances and available healthcare facilities
- New approaches must aim to allow for the appropriate use of resources to match patient needs appropriately

## 3. First responders

- The First Responder Scheme should be developed further across remote and rural communities where possible and appropriate
- Consideration should be given to the increased use of first responders such as BASICS GPs and nurses
- Consideration should be given to the increased involvement of other emergency and voluntary agencies in delivering a first response
- The SAS must ensure a clear understanding amongst the public that First Responders are an additional support to the community and are not used 'instead' of the emergency response

## 4. Referral pathways

- There are limited referral pathways available for remote and rural communities and patients are concerned about accessing specialist help quickly enough. The SAS must play its part alongside the wider NHS to ensure that all available resources are working together and can be accessed easily
- There is a role for the SAS to provide non-emergency treatment where access to practitioners is not always easy
- Patients would be happy to be treated at home as long as they can trust paramedic experience and qualifications and the SAS must ensure clear communication of the paramedic skills available to a community and work to develop a sense of trust with patients

## 5. Developing community engagement and resilience

- It is recommended that the SAS develops and implements a strategy for developing community engagement and resilience in remote & rural communities, urban communities and minority communities. To include:
  - Working with communities and partner organisations for education and development to foster a collective responsibility for healthcare
  - Community involvement in planning and delivery
  - Training and development in communities
  - Joint working with partners to improve the delivery of healthcare
  - Shared resources

## 6. Getting patients to and from hospital

- It is recommended that the SAS plays a part in assisting the development of improved co-ordination of transport resources for healthcare needs in remote and rural areas

## 7. Managing expectations

- The SAS will genuinely explore opportunities to share resources and develop integrated healthcare provision, working with all partners, including communities, to ensure that expectations are understood and considered

## Getting patients to and from hospital

### 1. Improving the Patient Transport Service

- Improvements are required to ensure the current Patient Transport Service is effective and meeting patients needs

### 2. Assessing patient need

- The current eligibility criteria for the PTS should be reviewed in collaboration with partner organisations
- The SAS must clarify entitlement to the PTS based on clinical criteria and consider the services that are possible to meet social and geographic need in the context of the Healthcare Transport Framework

### 3. Planning and co-ordinating journeys

The SAS must ensure co-ordinated systems and processes for PTS bookings and service delivery. This must include:

- Clear and consistent procedures and processes for making bookings
- Appropriate matching of responding resources to patient need
- Greater co-ordination with partner organisations to ensure a co-ordinated service for patients
- The SAS must govern the application of criteria, setting clear guidelines for application across partner services and ensure robust compliance

### 4. Partnership working

- It is recommended that the SAS works jointly with other transport agencies to support development of an integrated transport solution for the public and patients which will enable signposting and ease of accessibility to alternative services
- The SAS should explore the possibility of sharing PTS and community transport vehicles as part of an integrated solution

## Recommendations

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### 5. Extending the service

- As a result of specific requests from partner organisations, the SAS should consider the increased hours of operation of the PTS, especially to service out of hours requests
- There is also a need to consider the extension of the PTS to service non-hospital appointments such as GP, optician, day care appointments

### 6. Public education and engagement

- Revised eligibility criteria and improved processes will require clear and concise education and communication with partners and the public

## Enhancing the care we provide

### 1. Extending the SAS contribution to NHSScotland

- It is recommended that the SAS continues to develop its core services over the next three years
- The SAS should continue to explore enhancement opportunities that could create capacity in core service provision through better ways of working in collaboration with partners



**Scottish Ambulance Service**

National Headquarters, Tipperlinn Road, Edinburgh EH10 5UU

Tel: 0131 446 7000

[www.scottishambulance.com](http://www.scottishambulance.com)

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