

Remote Scottish Ambulance Service Response Audit

Report

Introduction

As part of the Remote and Rural Project's process to define the role and function of a Rural General Hospital (RGH), and the Framework for remote Primary Care (PCF) a series of focus groups were undertaken during the spring/summer of 2006.

The need for practitioners in remote areas and those working in Community Hospitals to have robust transport support has been a feature of discussions. In particular the responsiveness of the Scottish Ambulance Service (SAS) to remote needs has been challenged. This challenge, however, seems to be based upon anecdote. There is, therefore, a need to look at the evidence on remote SAS performance. The purpose of this project, therefore, is to work with remote practitioners and ambulance service colleagues to undertake an audit on the performance of the SAS within two remote areas in order to provide evidence on actual performance. The objectives of the audit were identified as follows:

1. To identify transport requirements to support healthcare provision in remote areas.
2. To agree the specific performance targets for measurement within the project.
3. To measure the performance against targets over an agreed reference period, dependant on accessible data.
4. To provide an audit report to the Remote and Rural Steering Group.

In order to ensure that the needs of different geographical remote communities could be reflected it was decided to undertake two mirror audits; one in North West Sutherland and one in Wigtownshire. Representation was sought from a General Practitioner, Operational Manager and SAS Manager from the respective areas. The Audits were facilitated by the Remote and Rural Project Manager.

This report outlines the findings of this project.

Methodology

The groups agreed core data set for collection. These were:

1. Category A and B response times for the relevant communities against SAS targets;
2. The number of incidences of single crewed responses within the respective geographical areas; and
3. Achievement of GP urgent calls within agreed timescale.

It was agreed that inter-hospital transfer data would be useful, however it would not form part of the baseline audit.

Definitions

The targets for response times within the period of the study were:

Category A Calls: National targets for Category A calls within the period of the study were that 63% of calls should be responded to within 8 minutes moving to an increased target of 75% of calls should be responded to within 8 minutes by the latter quarter of 2007/8. This is a national target for Scotland and for each Health Board area and does not reflect each geographical area.

Category B Calls: National targets for Category B Calls for the period of the study are that 95% of Category B Calls are responded to within 14, 19 or 21 minutes depending on population density.
All rural areas have a 21 minute response target.

GP Urgent Calls: 95% of GP calls should have a crew in attendance within 15 minutes of the agreed timescale.

Results

SAS Category A and B Response Times 2006/07

Location	Cat A No of Calls	% of Target Met	Cat B No of Calls	% of Target Met	GP Calls No of Calls	% of Target Met
North West Sutherland						
Wick	224	60.3%	396	89.6%	778	97.3%
Thurso	194	54.6%	355	88.5%	580	97.1%
Bettyhill	10	1%	42	76.2%	87	94.3%
Lochinver	6	16.7%	28	53.6%	79	97.5%
Wigtownshire						
Gatehouse of Fleet	91	33%	265	77.7%	250	90%
Newton Stewart	178	54.5%	554	82.7%	560	87%
Stranraer	417	76.3%	947	93.7%	782	88%
Whithorn	5	80%	9	88.9%	8	75%

Source: Scottish Ambulance Service ORCON System Apr2006 to May 2007

Single Crew Response Results

	No. of Vehicle Requests	% of Vehicle Requests supplied single crewed response
North West Sutherland		
Wick	243	4.1%
Thurso	212	6%
Bettyhill	25	0%
Lochinver	17	0%
Wigtownshire		
Gatehouse of Fleet	86	6%
Newton Stewart	263	1%
Stranraer	302	1%
Whithorn	9	0%

Source: SAS Emergency Medical Despatch Centre 2 month data. This data reflect each case received during April & May 2007.

Discussion

SAS Response Times

Results for Category A responses ranged from 1%-80% against a national target of 63% of calls to be responded to within 8 minutes. However, only 2 out of the 8 localities audited met this national 63% target. There are no local targets set and overall performance is measured by Health Board area. Results showed that in geographical locations where there is a higher density of population and locally based SAS crews, response times generally mirror or better those of urban areas. However, results also demonstrated that as the more rural the area, the longer the response time is likely to be, with the range being from 1% of calls being met

within the 8 minute target to a high of 33%. This however is more reflective of geography and road network than base resources.

Results for Category B response showed a significantly higher level of target achievement with the range being from 54% to 94% of calls being responded to within 21 minutes. With a similar performance achievement against GP Urgent call targets.

Discussion within the respective audit groups revealed that there had been a wide variation in interpretation of request times for ambulances. For example, when a General Practitioner requested a vehicle within the hour, he expected that vehicle to arrive within the hour. On the other hand, the despatch team may interpret that same request as SAS having a one hour period *before* having to request a response team. Since completion of the audit, criteria for ambulance requests have been revised and reissued in order to resolve this problem.

Single Crewed Vehicle Response

The Project experienced difficulty in obtaining data on single crewed vehicle responses. This was mainly due to the way in which vehicle despatches are recorded. For example, where the records showing single crewed vehicle responses, this also included Rapid Response Units, which by their nature are single crewed vehicles and this may have been the appropriate vehicle to respond to the situation. That said, results showed that remote and rural areas are still experiencing a level of single person vehicle responses. The data indicated that the level of single vehicle response rate had increased since the national terms and conditions for on-call payments within Agenda for Change had been implemented¹.

Conclusions

The purpose of this project was to work with remote practitioners and ambulance service colleagues to undertake an audit on the performance of the SAS within two remote areas in order to provide evidence on actual performance.

Evidence has been provided through this audit which supports some of the initial anecdotal findings from the Remote and Rural Project Focus Groups. Some remote areas do experience longer SAS response times but not to the extent as feared. There is a level of single crew vehicle response but this is not due to staffing levels within the Service. The main

¹ (2005) "Agenda for Change: Pay Modernisation" 2005 Department of Health

contributing factor to single crewed responses is associated to Agenda for Change Pay Modernisation.

There needs to be a debate as to whether it is reasonable to set a target of 8 minutes for Category A response in remote geographical areas, or whether a more creative community response is required utilising existing schemes such as the SAS 1st Responder Schemes, GP's, Community Nurse Responders, Community Paramedics etc.

The transport infrastructure should reflect actual patient need and the use of an Accident & Emergency Ambulance may be removing a vital resource from a rural area for a considerable length of time.

The debate around the transport infrastructure required to support practitioners in remote areas and those working in Community Hospitals needs to consider all the alternatives available including, public transport, volunteers, inter-hospital transfers, preferred appointments etc.

It is difficult to draw any hard conclusions from the single crewed vehicle response data, however, it is understood that there has been a national impact of Agenda for Change on-call payments and that this is being addressed centrally.

This report will now be submitted to the Remote and Rural Steering Group and also submitted to the SAS Rural Solutions Board so that through partnership working the response to remote and rural communities can be improved.

Group Membership

Dumfries & Galloway

Dr Gordon Baird, GP Stranraer

Mr Gus McLean, SAS Service Redesign Manager, South West Region

Mrs Alison Burns, CHP General Manager, Stranraer

NHS Highland

Dr Andreas Herfurt, GP Armadale

Mr Robert Colburn, SAS General Manager, Highlands and Western Isles

Mrs Fiona Duff, Primary Care Advisor, North Highland CHP

Remote and Rural

Mrs Fiona Grant, Remote and Rural Project Manager

Steering Group