An involving service

Ambulance responses in urban and rural areas

The challenge of responding to emergencies in rural areas has long been an issue for NHS ambulance services, politicians and the public. While it is not possible to get to rural locations as quickly as urban ones, patients need to know they will get an appropriate level of service should they need to call the ambulance service. Despite very high public satisfaction with ambulance services overall, ambulance performance in rural areas has been the subject of concern in some places.

This Briefing aims to help NHS organisations engage with local leaders, communities and other public services about the issues and challenges ambulance services face in rural areas. It sets out some of the solutions rural ambulance services have devised to help them deliver high-quality urgent care to rural communities, and is intended to start a conversation with local leaders and other public services about how best to work together for patients.

Key points

- Patients, rightly, expect a high level of service, wherever they live.
- Trusts need to address the public’s expectation of clinically consistent response times in all parts of the country through involving local communities in the assessment and delivery of services in rural areas.
- The move to clinical quality indicators changes the emphasis from time to treatment to effectiveness of treatment.
- All parts of the local health system must work together to ensure that the patient gets as rapid and effective a response as possible, and many rural trusts have already devised a range of solutions.

The June 2011 National Audit Office (NAO) report, Transforming NHS ambulance services, summed up the issues:

“Rural areas present inherent challenges for an efficient, fast responding service because calls are less frequent and widely spaced.”

Patients, rightly, expect a high level of service, wherever they live. But, most hospitals are in urban areas, meaning shorter journeys for city and town-based patients, and any delays caused by slow turnarounds can be minimised. In addition, during especially treacherous weather, such as snow
and flooding, rural areas are often significantly harder to get to than urban ones.

At the same time, demand for ambulance services is easier to predict in urban areas because more people live there, there are more incidents to attend and, therefore, more data is available on which to make predictions.

The wider context: a threefold challenge
As in all parts of the health service, ambulance services are faced by three challenges:

1. Ambulance trusts are part of an NHS system that has to make unprecedented efficiency savings of around £15–£20 billion by 2014.
2. The NHS reforms will fundamentally alter how local services are commissioned and how accountable they will be to local people.
3. Ambulance services face rising demand each year.

Unprecedented efficiency savings
Ambulance trusts are on the front line of the NHS, and services need to be constantly and consistently accessible 24 hours a day, every day of the year. The decisions made by ambulance staff can affect which treatments are offered to the patient further along the care pathway.

The recent NAO report highlighted examples of best practice that, if the learning is taken up by all trusts, could improve patient experience and response times.

If all trusts delivered the best current practice, the NAO report estimates savings of £165 million per year, although most of these savings would accrue to other NHS organisations locally. By developing alternative pathways, transporting to minor injuries units rather than A&E, and by treating more patients through telephone advice (‘hear and treat’) or mobile healthcare (‘see and treat’) interventions without transporting, the contribution of ambulance trusts to efficiency savings across a local system could be extensive.

There is massive potential therefore for ambulance services to be at the forefront when designing local urgent and emergency care systems so patients get better care.

Figure 1. Performance against the Category A eight minute response target for primary care trusts, by level of rurality, 2009–10

<table>
<thead>
<tr>
<th>Percentage responded to within eight minutes</th>
<th>Level of rurality (quartiles)</th>
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<tbody>
<tr>
<td>90</td>
<td>Upper 72.9</td>
</tr>
<tr>
<td>85</td>
<td>Mid-point 71.5</td>
</tr>
<tr>
<td>80</td>
<td>Lower 70.0</td>
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<tr>
<td>75</td>
<td>76.9</td>
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<td>70</td>
<td>74.8</td>
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<tr>
<td>65</td>
<td>72.7</td>
</tr>
<tr>
<td>60</td>
<td>74.5</td>
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Note
The circle represents the mean and the bar represents two standard errors. The maximum and minimum values may fall outside these ranges.

Source: National Audit Office analysis of ambulance service data, from Transforming NHS ambulance services

‘If all trusts delivered the best current practice, the NAO report estimates savings of £165 million per year’
and taxpayers get better value for money.

**Commissioning and accountability of local services**

Some aspects of the Government’s NHS reform programme – specifically the NHS 111 service – offer important opportunities for NHS ambulance services to improve urgent and emergency care for patients. Getting this service working to its full potential will require coordinated action across different services. Central to this will be clear commissioning arrangements between local, regional and national levels.

However, a September 2011 Public Accounts Committee report into the future of ambulance services stated that: “The Department [of Health] was unable to tell us who will be responsible for commissioning ambulance services under the NHS reforms.”

The Ambulance Service Network shares the concerns of the committee and believes urgent clarification is required from the Department of Health on how ambulance services will be commissioned under its reform plans.

Commissioning ambulance services is complicated. The range of activities undertaken by ambulance trusts means that the commissioning of different elements of the service needs to be at the most appropriate level in the system and, for some services, such as emergency 999 calls and the 111 system, at a regional or even national level. However, local urgent care services need to be commissioned by clinical commissioning groups at local level and, more importantly, with the full participation of local people and other health organisations if they are to truly meet the needs of both urban and rural communities.

This means, along with other clinicians, ambulance professionals must be part of local clinical networks, and the role they can play in changing patterns of demand should be recognised in health and well-being plans.

**Rising demand**

Demand for ambulances has been increasing at an unsustainable rate for some time. For the last three years, ambulance 999 call volumes have been increasing by 4 per cent, outstripping population and funding growth. 2010/11 figures show that call volumes passed the 8 million mark, equivalent to one 999 call for every six people in England.

Research shows that many of the people who call for ambulance services could be treated more appropriately somewhere else, and that there is great potential for savings through increasing ‘hear and treat’ and ‘see and treat’ activities and conveying to destinations other than A&E. Being flexible in different areas therefore makes sense for both patients and taxpayers.

**National ambulance targets**

**Category A** – life-threatening emergency. An emergency response should reach the patient within eight minutes in 75 per cent of all cases (the A8 target).

**Category B** – serious but not immediately life-threatening. An appropriate response should reach the patient within 19 minutes in 95 per cent of all cases (the B19 target).

**The 111 service**

The 111 telephone service, launched in August 2010, was set up to take pressure off the 999 service for patients who need help quickly but whose condition is not life threatening.

Call handlers assess the problem and an ambulance is dispatched immediately if it is an emergency. They provide immediate medical advice and direct patients who don’t need an ambulance to the most appropriate service.

**From targets to clinical quality indicators**

Until recently, ambulance trusts were principally performance managed against two time-based targets (see box above). For the
In April 2011 the Government announced a new set of performance indicators for ambulance services to replace the Category B target and with more emphasis on outcomes. While speed of response will continue to be a vital part of the service on offer – especially for the most serious incidents – ambulance trusts are now measured more on the clinical effectiveness of the services they offer rather than response times alone.

Getting to the patient in the rural location

Rural ambulance services have developed a range of solutions to help reach patients in rural areas. Many of these involve working with other parts of the NHS and local public services or charities. Part of the approach is to work with local communities to build up local resilience so that a safe ‘first response’ can be started while the ambulance team is on its way.

Developing community responses

Volunteer driver schemes can deflect some 999 calls by offering an alternative method of transport to hospitals.

Case study: Community first responder schemes

South Central Ambulance Service NHS Trust has a body of 200 community first responder schemes, with more than 1,500 members. In 2008/09 these schemes contributed to 11 per cent of the trust’s A8 performance. There are plans to increase this by an extra 550 people, which equates to an extra 2.5 per cent contribution towards the A8 target. It is worth noting that almost all the trust’s patient transfer service for moving patients back home or to other community services is performed by volunteers.

In 2008/09 the East of England Ambulance Service NHS Trust community responder schemes had approximately 2,000 volunteers, provided 985,550 hours of cover per year and attended 14,857 emergency calls.

Case study: North East Ambulance Service NHS Trust

North East Ambulance Service NHS Trust works in partnership with the North of Tyne Mountain Rescue Team (NoTMRT), one of several mountain rescue teams based in the North East. Formed in the 1980s in response to an increasing number of incidents occurring on the Northumbrian hills, the team provides search and rescue cover to Northumbria Police for any remote and open area of Northumberland and Tyne and Wear. It is available 24 hours a day, 365 days a year.

NoTMRT has 37 qualified hill members and five trainees. The team consists of unpaid volunteers, including two paramedics, one trainee paramedic and three nurses. In addition to assisting the police, NoTMRT assists the North East Ambulance Service in times of increased demand.
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A considerable impact on patient survival rates.

Partnership approaches: air ambulances

Air ambulances are another important part of responding to emergencies in rural areas as well as cities. Funded through voluntary contributions, their introduction in 1987 was a major development in transporting seriously ill or injured patients where access is difficult and best care is dependent upon the speed of response. An aircraft with two paramedics is the most common staffing method and can often bring clinical care to the patient more quickly than a road ambulance. Paramedics are usually provided through the local NHS ambulance trust, although some air ambulances use pre-hospital medical staff instead.

Developing partnership working further

In addition to these examples of partnership working, there are further opportunities, involving primary, secondary and social care, to improve emergency and urgent care in rural areas. Developing partnership working further will have the added impact of balancing demand across the health system and lessening the need for additional investment in rural ambulance services.

Case study: Great Western Ambulance Service NHS Trust

Great Western Ambulance Service NHS Trust (GWAS) has developed a Public Access Defibrillators Scheme (PADS), placing automated external defibrillators (AEDs) in public places, meaning that the local community first responder can use the device before the ambulance’s arrival, providing the patient with a better outcome. GWAS, along with many other ambulance services, runs defibrillator and first aid training, thereby building capacity in local communities.

Working with the voluntary sector to improve capacity

Alongside community first responder schemes, ambulance services work with local emergency and other services to ensure that the initial response to an emergency situation can be dealt with effectively by others who might be first at the scene, such as fire and police service co-responder schemes and voluntary rescue services.

Providing community resources

The National Defibrillator Programme is a joint strategy between the British Heart Foundation, the Resuscitation Council (UK) and all NHS ambulance services. The main aim is to improve the success rate in the resuscitation of patients who have an out-of-hospital cardiac arrest. Automated external defibrillators (AEDs) are put in busy places where heart attacks are likely to occur, such as shopping centres, airports, hotels, cinemas, district and parish councils and post offices. AEDs can be used safely by members of the public, saving precious time before the ambulance crew arrives at the scene. These nationwide schemes are having a considerable impact on patient survival rates.

<table>
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<tr>
<th>Air ambulance statistics 2010</th>
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<tr>
<td>• 30 air ambulances contracted, leased or owned.</td>
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<tr>
<td>• Over 19,000 missions flown per year.</td>
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<td>• 177 emergency departments served.</td>
</tr>
<tr>
<td>• Annual income of approximately £46 million generated.</td>
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‘Greater partnership working could reduce the need for additional investment in rural ambulance services’

there are approximately 12,000 volunteers who participate in a variety of schemes located in local communities and serve the rural community.

Community volunteering includes ‘first responder’ schemes. These trained volunteers respond within their own communities, providing valuable treatment until the ambulance arrives. They are a vital part of rural communities and contribute greatly to the resilience and cohesion of local ambulance services. It is this valuable community goodwill that supports ambulance trusts in treating and caring for patients living in rural settings.
Burden on community services and hospitals. It would also support an approach where more patients are treated at home and in the community. Greater partnership working could reduce the need for additional investment in rural ambulance services as organisations share their resources, knowledge and capabilities.

The Government’s ‘Big Society’ aims to encourage communities to have more autonomy and for people to take more active roles in the community.³ Ambulance services are already involved in local partnership working and are paving the way for community schemes and local work to be expanded in the future. The organisations in the box opposite could be used as potential partners.

**Potential partners for ambulance services**
- social workers
- district nurses and midwives
- out-of-hours services
- district and parish councils
- fire service
- the police
- St John Ambulance
- The Red Cross
- pharmacies
- dental practices
- opticians
- hotels
- cinemas
- post offices
- schools and colleges

### Working with primary care

Closer integration of ambulance services with local primary care in rural areas could enable speedier triage of patients’ urgent care needs, both in and out of GP surgery hours, and also expand the range of services that could be provided in the community, such as administering home-based intravenous antibiotic treatment.

The use of community paramedics in a rural part of Northumberland is an existing practice devised by the North East Ambulance Service owing to the need to better integrate the local health community to provide appropriate care. The trust’s collaboration with a local GP established a community paramedic at the GP surgery, on duty 24 hours a day, seven days a week. The success of this scheme has been due to the involvement of the local population working in partnership with the local healthcare providers to provide a locally appropriate solution.

### Developing community capacity through public health initiatives

Ambulance services are involved with many public health initiatives. These schemes provide opportunities to establish new partnerships within local communities. Ambulance services receive a high number of requests to visit schools and to provide

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**Case study: Public health initiatives**

London Ambulance Service NHS Trust organises a Junior Citizen Scheme which seeks to educate pupils about what to do in a medical emergency as well as explaining the role of the ambulance service in the community. North East Ambulance Services NHS Trust, in conjunction with The Children’s Safety Education Foundation, has launched a major campaign to provide primary school children throughout the North East with life-saving first aid handbooks. The guidebooks aim to teach children aged between six and 11 about their bodies, how to look after them, how to recognise a medical emergency and how to respond.

The South West Ambulance Service’s Community Engagement Team manages first responders, promotes heart health and provides school liaison as well as promoting the work of the ambulance service at public events at farm shops, rural shows and shopping centres. The department researches possible new schemes and initiatives, promotes volunteering and fundraising for equipment and coordinates partnership working.
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basic life support and other safety awareness training.

Using local networks to develop new services
New schemes come about in many different ways – for example, when the ambulance service reviews where response time targets are not being met or where there is an increase in 999 calls. If there is enough work to sustain a volunteer scheme, the ambulance service will approach local organisations to discuss working together. Similarly, if the ambulance service regularly visits a shopping or leisure centre, it will become apparent that further help is required so that patients receive rapid access to care. Working together in this way guarantees that the patient will receive prompt help while the organisation receives good quality training and equipment provided free of charge.

Ambulance Service Network viewpoint
As in other parts of the NHS, ambulance services face a threefold challenge: unprecedented NHS efficiency savings; the implications of the current NHS reforms; and tackling increasing demand in services.

But population spread and geography present further challenges and mean different ways must be found to provide timely, high-quality and safe services in rural areas. Offering exactly the same service for rural areas as in urban ones would be financially unsustainable, and this Briefing sets out examples of how trusts are working with others to overcome the issue.

Time targets helped the ambulance service improve. But the targets did not recognise the fundamental differences between urban and rural areas.

It is early days for the new clinical quality indicators, but we welcome moves by the Government to focus more on patient outcomes. With this comes the potential to offer more innovative services that better suit the nature of local demand and need.

As this Briefing shows, ambulance services are already focusing on increasing the ability and resilience of isolated communities to provide their own first response care services, working in tandem with ambulance trusts and the wider NHS.

Because the decisions ambulance service staff make can affect future spending as patients are taken to different services, it is important to have the right commissioning structures in place at local, regional and national levels to make sure care is organised properly, so patients get to the right place, at the right time, every time.

Effective coordination of commissioning of these services, bringing communities together with different parts of the NHS and wider public services, has led to ambulance trusts being successful in improving services and meeting local need. However, this principle should be applied to the entire urgent and emergency care system rather than solely rural areas.

The Government’s move to a focus on outcomes is welcome and provides a more appropriate framework within which to properly meet the urgent and emergency care needs of patients, wherever they live. But a great deal of uncertainty remains in the wider reform programme as to how ambulance services will be commissioned. We urge the Department of Health to clarify this.

Ambulance services have the clinical expertise and knowledge to play a key role in improving the urgent and emergency care system. They need to know how they will be commissioned at local, regional and national level so they know how their performance will be measured, who they are accountable to and, most importantly, so they can use their expertise and work with others to improve services for patients, regardless of where they live.

For more information on the issues covered in this Briefing, contact jo.webber@nhsconfed.org

‘Ambulance services are already focusing on increasing the ability and resilience of isolated communities to provide their own first response care services’
The Ambulance Service Network

The Ambulance Service Network (ASN) was established as part of the NHS Confederation to enable the ambulance service to work more closely with other parts of the health service, while retaining a strong, independent voice for NHS and public ambulance services in the UK.

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