

Scottish Ambulance Service Strategy Refresh – gathering views on ‘Hear and Treat’ and ‘See and Treat’

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1. Introduction

The Scottish Ambulance Service requested the support of the Scottish Health Council to convene a number of discussion groups across Scotland to engage with members of the public and gather views on their 'Hear and Treat' and 'See and Treat' protocols.

When the Scottish Ambulance Service implement these protocols it will mean that it delivers care to people so that they do not have to go into hospital but rather they can stay at home with local care support around them. This approach is supporting the Scottish Ambulance Service to meet the Scottish Government's 2020 vision that "everyone is able to live longer healthier lives at home, or in a homely setting."

The Scottish Ambulance Service acknowledged that some patients and carers may be anxious about this approach and so would like to understand what is required to make this a positive experience for those who may require assistance from the Service. Using the Scottish Health Council's local office network the Scottish Ambulance Service wanted to get a sense of how this would feel for remote, rural, island and urban communities across a range of people who may call on the Service.

2. Process

In total, 63 people participated in seven discussion groups organised by the Scottish Health Council across Scotland between November 2014 and December 2014. The numbers of participants at each group varied with three being the minimum and 23 being the maximum.

Each discussion group focused on a target population – these were young people (primary school pupils), people with a long term condition, people from a black and minority ethnic (BME) background, people living in a remote/rural setting, people living in an island community, users of mental health services and people with carer responsibilities. While it was acknowledged that this list was not exhaustive it was felt that the audience gave a ‘cross section’ which would give a reasonable span of different perspectives.

The Scottish Health Council local offices which participated in this project comprised Ayrshire and Arran, Grampian, Greater Glasgow and Clyde, Orkney, Tayside and Western Isles. The geographical spread ensured a good mix of both urban and rural representation. Appendix 1 contains a list of the discussion sessions which took place.

Each discussion group followed a similar format however the time for each group varied from one to three hours dependent on the needs of the group. With the exception of one group, each group had members of the Scottish Ambulance Service in attendance to discuss its work and answer any specific questions participants had. Due to operational demands it was not possible to have the Scottish Ambulance Service represented at the group with people from a BME background, however any questions that were raised were shared and the Service has committed to attending a future meeting of this group in 2015.

Each discussion group started with a presentation from a representative from the Scottish Ambulance Service which outlined the ‘Hear and Treat’ and ‘See and Treat’ protocols and set the scene for the discussion. The slide presentation and format of the discussion group at each group was broadly similar although the way the information was presented was adapted to make it suitable and engaging for the participants who were attending.

Participants were taken through some case study examples of what the ‘Hear and Treat’ and ‘See and Treat’ protocols may look like in practice and asked to discuss some questions around the themes of triage, sharing information about you, communicating with you and new care pathways.

For the session that took place with young people the discussion was supplemented with some interactive activities. These activities included reviewing X-rays, demonstrating what it would be like to have arthritis in the feet and hands, and what it would be like if you had a visual impairment. At the end of this session the young people were given the opportunity to go into an ambulance, test some of the equipment and ask the paramedic in attendance any questions.

The comments made by participants across the seven discussion sessions are

listed in Appendix 2. A report from each individual session was produced and this was shared with participants to ensure factual accuracy. Prior to the facilitated discussion, participants were encouraged to ask questions to support their understanding of the topic – the questions raised, comments made, and response to these can be found in the reports from each discussion group which are available on request.

Participants at each session were asked to complete an evaluation form to give their feedback on the event. For the session that took place with young people we used a feedback line to gather the views from the children in a fun and visual way. The results of this evaluation are very positive and are available from the Scottish Health Council on request.

3. Feedback from Discussion Groups

The comments relating to the discussion questions made by participants across the seven sessions are listed in Appendix 2. Summarised feedback on each of the discussion questions is noted below.

Q1) If you were to call 999 for an ambulance, would you expect your call to be triaged¹ – and that we might not send an ambulance, but put in place an alternative response?

“The consensus of the group was that the general public would not expect anything other than an ambulance to arrive following a 999 call. This is not to say that the general public would not welcome any other care, they are just unaware of the possibility of this happening.”

In all but one of the groups (Mental Health Service Users) comment was raised that people would expect an ambulance to be sent in response to an emergency call. Even in the group where such comment was not specifically made it was assumed and comments were made about the difficulties or issues that not sending an ambulance would raise. One participant commented: “The perception of poor cover in the area would be worsened by this.”

Participants in a number of groups (Remote and Rural, Carers, Island Community and Long Term Conditions) went on to add that the Ambulance Service would not only need to make clear to emergency callers that triage would take place and that an ambulance may not be sent, but would also need to conduct an information exercise with the general public. One participant commented: “The Ambulance Service needs to communicate to the wider public about changes to the Service and what it now provides, including how triage works and that an ambulance may not be sent.”

Triage itself gave rise to a wide range of comments across most of the groups. Although there was only general support expressed by two of the groups (Mental Health Service Users and Remote and Rural) for triage, most other comments consisted of qualifications or suggestions as to what would make triage workable and acceptable from the public’s point of view. In three of the groups (Carers, Island Community and Mental Health Service Users) participants flagged up the need to keep the triage short so as “not to add stress to the situation” and distinct from NHS 24 in order to avoid duplication. The matter of who conducted triage was also considered in two of the groups (Island Community and Remote and Rural) with a number of participants calling for this to be conducted by clinical staff/staff with medical knowledge – “this would give some assurance and comfort that the skill set of the call handler was appropriate”. However in one group in particular (BME) some participants expressed anxieties about triage if it were to be conducted without language support being available.

Finally there were some comments to note with regard to the Ambulance Service

¹ Triage is the practice of sorting emergency patients into categories of priority for treatment

putting in place an alternative response as opposed to sending an ambulance and/or taking a patient to hospital. In the Remote and Rural group there was discussion about the value and the need to have First Responder Schemes in place but also a call for the Ambulance Service to make best use of the wider network of professionals in rural communities. In the Long Term Conditions group suggestion was made that lower 'tech' vehicles might be used in situations where a full ambulance was not required, although a participant in the Carers group felt that an ambulance car should not attend an emergency call on its own. Keeping people out of hospital as a result of Ambulance Service triage and treatment was particularly supported by the Mental Health Service Users' and Young People's groups.

Q2) How do you feel about the Scottish Ambulance Service accessing and sharing your medical information about you?

"If I've phoned for help I don't really care who knows what about me as long as they can help me."

Across all of the groups there were statements of support for the accessing and sharing of medical information. In the Long Term Conditions group for example, "the consensus of the group was that access to these records can only be a good thing as it aids diagnosis and is part of a more holistic approach. Having the right information helps the patient whereas lack of information puts the patient's safety at risk".

Some participants stated that they believed information sharing was common practice already and in the Remote and Rural group it was felt that "most people already assumed that information was shared". In the Island Community group some participants stated that it should be a 'given' that Scottish Ambulance Service staff have access to their medical information and that it was in the patient's best interests for this to happen. However, in the Young People's group there was a mixed response with two thirds of participants expressing concern about their personal information being shared between the Scottish Ambulance Service and other healthcare workers.

The sharing of information between the Scottish Ambulance Service and GPs was a topic which generated a number of comments. Most of these highlighted the perceived benefits to a patient's overall care if the Ambulance Service provided information on treatment/care they had provided. However some participants raised concerns about the accuracy and completeness of records held by GPs/other healthcare professionals, flagging up that this could hamper the Ambulance Service in making decisions for patients. The BME group also had concerns about the accuracy of information – noting that language barriers can lead to misinterpretation of information.

Governance issues around the access and sharing of patient information were also discussed across the groups. In the Island Community group the consensus was that:

"This change to share medical records with the Ambulance Service would require robust governance" and that "data shared must be relevant to patient conditions

at that particular time and information only accessed at time of call-out". In two of the groups (Carers and Island Community) consideration of patient/public sensitivities led some participants to suggest patient permission was required. However in the Carers group there was comment that confidentiality can be used as a barrier – "surely they need to know what medications I'm on as the wrong medication could kill me".

Discussions on governance issues also raised the issue of the need for compatible IT systems between the different parts of the healthcare system (Carers group) and fears that agreeing all the necessary protocols and safeguards might be a prolonged business based on previous experience (Remote and Rural group).

Finally, in the Carers group, the point was made that enabling the access and sharing of information also creates a requirement for staff to read the information that is available before taking clinical decisions.

Q3) Increasingly, more areas of the NHS (GPs, Clinics, Scottish Ambulance Service) will be sharing your information to make sure that you get the right care and treatment, when you need it. How should we communicate that to you?

"Use social media and TV for a joint marketing campaign with NHS24..... include that access to patient's information will be shared with other NHS services in order to ensure the best possible care and treatment so that the general public is aware of this happening."

Discussion generated by this question produced a variety of responses across all groups.

The suggested means or settings for communication were varied. In the Remote and Rural group and in the Carers group the GP surgery was seen to be a natural choice:

"The process should be explained at the GP surgery as that is where most treatments start out".

For participants in the BME and Young People's groups going to where communities are/meet was the preferred starting point, and the latter group emphasised that "making it fun" should be a feature of the exercise. In the Long Term Conditions and Remote and Rural groups some participants felt the communication should be spearheaded by media-based marketing campaigns, although the latter group felt that there were weaknesses in recent information campaigns held by some national organisations highlighting their change in telephone number from which lessons needed to be learned. The Remote and Rural group also considered the practical needs of people who are housebound, and there was discussion about the pros and cons of channelling information via home helps and carers.

For participants in a number of groups (Carers, Island Community and Long Term Conditions) communication of proposed actual sharing of personal information

would be made as part of an opt in/opt out process or alternatively completion of ad hoc consent forms. Discussion of these processes also led to calls for “reassurance around security and confidentiality of information” and “careful consideration” of “ethical issues regarding the availability of patient data prior to the introduction of any change”.

Finally, discussion of this question also led to comment that sharing of information should not only be a matter of data being transmitted between healthcare professionals and agencies but also sharing should include information given to patients about their condition/treatment received.

Q4) How do you feel about not taking patients to hospital?

“The groups agreed that if a patient doesn’t need to be in hospital, don’t take them there.”

In all but two of the groups (BME and Carers) participants were comfortable with the concept of the Scottish Ambulance Service not taking all of their emergency call patients to hospital. In the Remote and Rural group “the general feeling was that ‘this is why triage is done’ and they would expect to be triaged”. However, in the Carers group some anxieties were expressed and participants flagged up a number of conditions which would need to be in place or addressed for them to be more comfortable with ‘Hear and Treat’ and ‘See and Treat’ such as education for the public and doctors, having adequate resources in place and joined-up services to support such protocols. In the BME group, although there were statements of support, some participants noted that their support for such protocols might only be theoretical and might not stand up to actual test, particularly if it concerned the response to the “decision about someone else, for example if you are a carer of an older person/child”.

In the Mental Health Service Users and Remote and Rural groups there was recognition that triage and shared information could bring benefits in terms of combating treatment delays and improved efficiencies. However, in the Island Community group, there was comment that efficiency savings needed to be considered across the healthcare sector:

“One organisation’s efficiency savings are not necessarily benefitting another or its clients”.

The same group also emphasised that the primary reason for change should not be alleviating pressures on Accident and Emergency units, rather that “the patient receives care that is best for them as individuals”.

Discussion group participants also considered other aspects of the care of Ambulance Service emergency call patients. One participant in the Long Term Conditions group gave an example which, for them, highlighted limitations in the current Ambulance Service triage system which only focused on the health condition being reported. There was also discussion in this group on what was felt to be the Ambulance Service’s need to develop its links with other agencies to support patients at home. This latter point concerning follow-up care

communication with other personnel was also flagged up in the Island Community and Remote and Rural groups – “there were concerns about communication with the patient and with their personnel who may have to provide follow-up care since poor communication is already a pervading feature in folks’ experience with different service providers”. Allied to these concerns about communication was a desire to have clarity around responsibility for follow-up care:

“Patients/carers need to be informed about follow-up treatment or care and whose responsibility it is to ensure this is in place.”

Finally, discussion in the Remote and Rural group about inter-agency communication proposed the creation of local healthcare hubs where GP practices, Ambulance Service staff and other healthcare workers could work together to make “best use of all the skilled staff available”. Associated with this there was a request for the greater use of telemedicine.

4. Evaluation

Following each discussion group, participants were asked to provide feedback on the event. Evaluation forms were used to capture feedback from attendees across six of the discussion groups with an alternative form of evaluation used at the group with the young people.

Out of the 40 people who participated in the discussions sessions where an evaluation form was issued, 27 people provided feedback (68% response rate). Unfortunately no evaluation forms were returned from participants who attended the users of Mental Health Service Users' session. All participants who completed an evaluation form provided positive feedback in terms of the topic being discussed, the opportunity to be actively involved in the discussions and the practicalities of the session itself (e.g. accessibility, special requirements being met). While all participants were positive about the discussion which took place at the sessions and the opportunity to increase their knowledge about the Scottish Ambulance Service, some participants highlighted that it would have been useful to have had more time allocated to the events.

To evaluate the session with young people, participants were asked to give their feedback by writing their comments on a flag and clipping it onto a 'feedback line'. The feedback from this session was very positive and that the young people had fun learning something new and enjoyed the interactive parts of the session.

5. Next Steps

This report and the reports from each discussion group have been shared with the Scottish Ambulance Service for their consideration and to inform their future work. The Scottish Health Council advises that the sample size within individual discussion groups within this project is such that themes and issues identified should be explored further by the Scottish Ambulance Service as it continues to engage with the public around its 'Hear and Treat' and 'See and Treat' protocols.

We would like to thank all of the participants who contributed to the discussion groups and the staff within the Scottish Health Council and Scottish Ambulance Service who supported this project.

Appendix 1: Discussion Groups facilitated by Scottish Health Council staff

Group	Discussion Group Details
People with a long term condition.	Group held on 10 November in Dundee with 12 members of the public from the Tayside area.
People living in a remote/rural setting	Group held on 12 November in Stornoway with three members of the Ness Community.
Young people	Group held on 18 November with 23 pupils from Darnley Primary School, Glasgow.
People living in an island community	Group held on 26 November in Orkney with nine people from an island community.
Users of mental health services	Group held on 27 November in Peterhead with eight users of mental health services.
People with carer responsibilities	Group held on 11 December in Prestwick with four members of the general public, three of whom had carer responsibilities.
People from a Black and Minority Ethnic (BME) background	Group held on 12 December with four members of a local women's BME Group in Glasgow.

Appendix 2: Feedback and comments from participants at facilitated discussion groups

The following section summarises feedback and comments from participants.

Q1) If you were to call 999 for an ambulance, would you expect your call to be triaged – and that we might not send an ambulance, but put in place an alternative response?

BME

- “Do you get immediate language translation?”
- “Would expect ambulance to be sent out immediately – it would add to the stress of the situation if we were asked questions.”
- “Need staff to ask/or answer questions in Urdu. Very difficult in English as I am not speaking in my own language – find this very stressful as I don’t know enough English.”
- “Could there be a different phone number to call for different languages?”
- “Would be fine with getting asked questions to determine what action should be taken.”

Carers

- “Yes.”
- “It’s not an unreasonable expectation.”
- “The public would expect an ambulance to come; you wouldn’t expect a car to come. If a car came I’d be asking ‘where’s the ambulance?’”
- “Education is crucial for the public.”
- “Is there adequate trained staff available?”
- “Merge NHS24 and the ambulance service – problem solved.”

Island Community

- The general consensus of the group was that if dialing 999, the caller would expect an ambulance to arrive at the site. If this would change you would have to educate the public about this.
- “Staff providing reassurance, and an explanation of what would happen over the phone, would be crucial in minimising patient/carers anxieties if triage were introduced.”
- “Triage would have to be short so that it remains distinct from NHS24 proceedings.”
- “The caller may not know what the specific issues with the patient are, especially, if they had just happened to come on the scene at/around the time of the illness or trauma.”
- “The response has to be tailored to the individual and his/her circumstances, and therefore it is important that clinical staff take the call.”

People with Long Term Conditions

- The consensus of the group was that the general public would not expect anything other than an ambulance to arrive following a 999 call. This is not to say that the general public would not welcome any other care, they just are unaware of the possibility of this happening.
- “The Ambulance Service needs to communicate to the wider public about changes to the Service and what it now provides, including how triage works and that an ambulance may not be sent.”
- “A person’s expectation of what care the Ambulance Service provides also depends on a person’s medical condition(s) and previous experience of the service.”
- “At the moment a person will expect an ambulance but in the future, could lower tech vehicles be used as a replacement when a full ambulance is not required?”

Mental Health Service Users

- “I am concerned about a lack of coverage in the area and am worried that the perception of poor cover in the area would be worsened by this.”
- “It can be hard to know which service to call already, this may make it more confusing.”
- The entire group were generally happy with the idea of additional triage if it led to an overall improvement in services and kept people out of hospital (unless they needed to be taken in).

People in Remote and Rural Settings

- The general feeling was that, yes, the expectation was that the call would be triaged – even if it meant a bit longer in terms of discussion with call handler. “The more information they have; the better the outcome.”
- The group thought that having a clinician or someone with medical knowledge doing the triage would be good. It was also thought to be important to tell the caller what ‘grade’ was dealing with the call – this would give some assurance and comfort that the skill set of the call handler was appropriate. There would also be comfort for the patient to know who was going to arrive and deal with the issue.
- Think about using the wider network of professionals in community.
- Sending an ambulance puts people at ease and some people do automatically expect an ambulance to be dispatched when calling 999. It was noted that often control rooms are not ‘user friendly’ while in many remote areas elderly patients/callers prefer to communicate in Gaelic i.e. their first language. There was a comment here that sometimes people, especially the elderly, do not expect a lot of questions to be asked.
- Often the public are not aware of the different level of skills and skilled staff within the service.
- It is important to have first responders in place in rural communities and it was noted that there are some good first responder schemes locally, however professional involvement is important and not to rely too much on volunteers. There was discussion and thought around the importance of telling patients

who will call on them and what the alternatives will be i.e. if someone other than an ambulance or paramedic will call, this would provide reassurance to vulnerable communities. Have the right people answering the right questions.

- “People need to have information and know what’s available”.
- There was discussion around providing education to the public and the housebound in particular. Could home-helpers and carers share this information with this group of people?
- There was a question around first responders and whether they would still be classed as volunteers in any changes.
- There was some discussion about the value of first responders to the rural communities with comments like “volunteers need to be able to access equipment at all times”. There was recognition that there are first responders in communities and some of them do have access to defibrillators etc. There was a suggestion to link with the fire service as there are highly trained staff within that service in local communities.

Young People

To tailor the questions to young people appropriately this question was combined with question four and they were asked “How would you feel if you or a member of your family was treated by the ambulance staff and didn’t have to go to hospital?”

- Two pupils highlighted very different responses – one said they would be “sad as I would want to go in an ambulance” while another said they would be “glad I didn’t have to go to hospital.”
- The majority of the feedback on the ‘post-it’ notes to this question was that people would be happy to stay at home as opposed to going to hospital.

Q2) How do you feel about the Scottish Ambulance Service accessing and sharing your medical information about you?

BME

- “Happy with that.”
- “This is a good idea although care needs to be taken to ensure the information held is accurate.”
- “Language barriers can lead to misinterpretation of information.”
- “It seems a practical/sensible thing to do.”

Carers

- Some people believed that this was common existing practice while others acknowledged that electronic systems aren’t currently compatible.
- “Great idea to share information with GPs.”
- “Need patient permission to access records.”
- “Confidentiality can be used as a barrier – surely they need to know what medications I’m on as the wrong medication could kill me.”
- “It makes sense to have access to an emergency care summary at least.”

- “If I’ve phoned for help I don’t really care who knows what about me as long as they can help me.”
- “You can’t follow an end-of-life/anticipatory care plan if you don’t know it exists.”
- “It’s important that shared information is actually read.”
- “Electronic systems need to be compatible.”

Island Community

- “If someone is calling for medical support, it should be a ‘given’ that Scottish Ambulance Service staff should have access to the necessary medical records in order to best support the patient.”
- The group recognised that in order to best treat the patient, Scottish Ambulance Service staff would need as much relevant medical information as possible, but that data shared must be relevant to the patient condition at that particular time and information only accessed at time of call-out.
- It was recognised that to provide a duty of care to the patient sharing between relevant medical teams is vital.
- “People should be made aware that the entire GP record would not be shared, but important information such as allergy and current medication would be accessible.”
- “The default position should be that this happens, but people could have option to opt out and have this recorded in their medical records.”
- Again the consensus was that, this change to share medical records with Scottish Ambulance Service staff, would require robust governance.
- “Staff need to be aware that what the patient explains about their own health issues and what has happened to them, may sometimes be their own perception rather than factual (patient safety issue).”
- “When patient dials 999, they should expect that it is in their best interests to have their information shared between medical teams.”

People with Long Term Conditions

- The participants assumed this happens anyway and the consensus of the group was that access to these records can only be a good thing as it aids diagnosis and is part of a more holistic approach. Having the right information helps the patient whereas lack of information puts the patient’s safety at risk.
- “It is vitally important that the patient’s GP is advised of the treatment provided and of the patient’s discharge.”
- There was concern from the group that GPs do not always keep patients’ records fully up to date and this will cause problems for the Ambulance Service when diagnosing/making decisions about a patient, putting patient safety at risk e.g. anticipatory care plans are often not up to date.

Mental Health Service Users

- One person thought that this already happened.
- Another commented that this would help to reduce delays in getting information to their own doctor.
- One participant thought that this would be a lot easier for patients as they

wouldn't have to wait for letters.

- Generally the whole group liked this idea. They felt it would speed up the process for both the Scottish Ambulance Service and other NHS services.

People in Remote and Rural Settings

- There was a general consensus that people were happy to have information about their health and care shared by medical professionals.
- One personal anecdote was shared about an occasion when someone needed care and the doctor had his notes and information when treating the patient.
- Comments like access “helps share information about my condition” and “It’s good if your doctor gets to know you’ve been to hospital or used an ambulance”.
- Another comment was that if the paramedic has access to your records prior to arrival then it’s reassuring that he has all the necessary information.
- The only two comments against the sharing of this type of information were that some people are sensitive about their information being shared and that it’s common for more than one person in the same house to share the same name – potentially leading to confusion.
- It was felt that most people already assumed that information was shared. There was one comment that the Single Shared Assessment took a long time to agree and embed so there were fears that this could be delayed too.
- With reference to the potential for confusion around identifying intended patient the group thought that an appropriate identification process be developed and they also wondered if Community Health Index (CHI) numbers were the way forward – if so, this would require some promotion and awareness-raising.

Young People

To tailor the questions to young people appropriately this question was changed to “How would you feel about the ambulance service sharing information about you to other healthcare workers?”

Pupils highlighted that they would be “worried” and “scared” if the Scottish Ambulance Service was to share information about them. There was mixed feedback on the ‘post-it’ notes to this question with most people highlighting that this would worry them but others noting that they would be ok. One person highlighted that it would be “a good idea to tell the doctor”.

Q3) Increasingly, more areas of the NHS (GPs, Clinics, Scottish Ambulance Service) will be sharing your information to make sure that you get the right care and treatment, when you need it. How should we communicate that to you?

BME

- “Word of mouth is the most effective way to do this.”

- “Use existing community links e.g. Mothers and Toddlers groups that share information and signpost people further.”
- “It is important to share initial information with the relevant community groups/organisations.”

Carers

- “There should be an ‘opt’ in or out process just like the Organ Donor Card system.”
- “The process should be explained at the GP surgery as that is where most treatments start out.”
- “There needs to be a reassurance around security and confidentiality of information.”
- “We should be carrying a card that gives our health details.”
- There was a discussion about ‘presumed consent’ i.e. the fact that you have made emergency contact then the consent is presumed.

Island Community

- “There could be a tick box on a consent form and patient must agree to this at time of consultation/intervention.”
- “Ethical issues regarding the availability of patient data need careful consideration prior to the introduction of any change.”

People with Long Term Conditions

- Again, the group consensus was that people assume this is happening now anyway.
- The group suggested using social media and a TV for a joint marketing campaign with NHS24. It was felt this would provide value to both NHS Boards as it would give an opportunity to explain to people where to contact for what, when and why. Include that access to patient’s information will be shared with other NHS services in order to ensure the best possible care and treatment so that the general public is aware of this happening.
- “Assume consent to share patient information with other NHS services but give patients an opportunity to opt out of this if they want to e.g. there may be people who are vulnerable and who do not want their information shared.”
- “If sharing information with other NHS services, are you also sharing it with the patient i.e. what you have done and what their needs are.”

Mental Health Service Users

- It was suggested that doctors at the GP surgery and other healthcare staff could be provided with leaflets and posters.
- “Local papers and radio stations could be used.”
- “TV adverts would reach a wider audience.”

People in Remote and Rural Settings

- It was acknowledged that there are lots of local /village/community

newsletters and magazines. Most people read a combination of these and the Stornoway Gazette – use an advert or an insert containing information. Using these local publications would reach a lot of people. There are also local radio stations - so use **local** media.

- “GP surgeries would also be a good place to target for example use posters.”
- The NHS24 campaign to promote the change of phone number wasn’t thought to be a great success – as with the new police non- emergency number. The group thought that the information was slow to get out.
- In terms of people who were housebound, it was thought that perhaps home-help and carers could assist with making their clients aware of the changes or intention to share information. Problems identified with this were; questions around whether it was a carer’s duty/responsibility and the time element of carer visits coupled with the fact the housebound may not see the same carer every visit.
- Other comments were that perhaps there was no need to notify people until the change was legal and had been made; again make use of local media and notify in writing so that people have written information to hand when they need to reference it.
- There was discussion about other services recently changing telephone numbers and the group were concerned about whether the Scottish Ambulance Service would be changing their emergency number. The group also noted that some other non-emergency numbers are no longer free of charge.

Young People

To tailor the questions to young people appropriately this question was changed to “How should the ambulance service involve children and young people to hear your views and make services better?”

- Pupils highlighted that it would be good to engage with them by “coming to their school” and by “making it fun”.
- This feedback was echoed in the ‘post-it’ notes with the majority of pupils stating that the service should come to where they are and that any engagement with them should be fun.

Q4) How do you feel about not taking patients to hospital?

BME

- “Would be ok if only in an emergency you needed to be taken into hospital.”
- “Ok – would rather be at home.”
- “Need to know why the questions are being asked.”
- “Sitting here I think ‘ok’, but in the situation I don’t know.”
- Harder to make that decision about someone else for example if you are a carer of an older person/child.

Carers

- During this discussion, some anxieties were expressed, and mainly by a participant who had much more involvement of NHS services than the others.
- “Nobody follows pathways anyway.”
- “Who will make the decision about who goes to hospital?”
- “Mental health will create a big challenge.”
- “Once again education of the public is vital.”
- “Everyone with a chronic long term condition should be educated in self management.”
- “It is essential that adequate resources are in place.”
- “As discussed previously, it is essential that there are joined-up services.”
- “Doctors need to be educated too so they understand the processes.”
- “We have the best ambulance service in the world, we’re very lucky.”

Island Community

- “Anything that can alleviate current pressures on existing medical provision must be good, so long as patient receives treatment and care that they need.”
- “One organisation’s efficiency savings are not necessarily benefitting another – or its clients.”
- “There is a moral issue in that the primary reason for change should not be to minimise attendance at A and E, but rather, to ensure the patient receives care that is best for them as individuals.”
- “Patient/carers need to be informed about follow-up treatment or care, and whose responsibility it is to ensure this is in place; who’s responsibility will that be?”
- There were concerns about communication with the patient and with other personnel who may have to provide follow-up care since poor communication is already a pervading feature in people’s experience with different service providers.

People with Long Term Conditions

- The group agreed that if a patient doesn’t need to be in hospital, don’t take them there.
- Before a patient (especially an older or vulnerable person) is discharged from hospital, different specialities e.g. physiotherapy and occupational therapy, assess whether they are able to stay at home and what support they may need. Where the Ambulance Service is the agency assessing and providing care for a vulnerable person at home they would likewise need to instigate a process for assessment of the patient’s ability to remain at home and what their needs are.
- One participant gave her experience of phoning 999 on behalf of an elderly relative who was at a different location but had carers with her. The patient was taken by ambulance to hospital and found to have a serious illness while there although the initial reason for the call was not found to be life threatening. There was concern that the triage process could also potentially

have led to the patient not being taken to hospital.

Mental Health Service Users

- The whole group were comfortable with the proposals.
- One participant felt that the triage system would help to combat delays and that an improvement in assessing patients needs could lead to a more efficient service.
- One participant felt that the general public weren't aware of the lack of resources and the need to triage better but if they understood the information communicated during the focus group then they would see the benefit of these proposed changes.

People in Remote and Rural Settings

- The group discussed this and the general feeling was that "this is why triage is done" and they would "expect to be triaged". They thought it would be good as long as the person doing the triage was suitably qualified and that the decision was appropriate to the call. There was a feeling that if medical records were shared then access to records would avoid delay in treatment and give the paramedic all the information needed to treat as soon as possible.
- There was discussion around IT systems and the need to invest in the infrastructure to enable this – but not at personal cost to individuals. Locally, enterprise companies could be involved in the IT aspect.
- There was also mention that if paramedics were not used then there was a risk that skills could be lost.
- Good communication between GPs, paramedics and other healthcare professionals was thought to be important, with the Scottish Ambulance Service notifying the GP if a call had been made – even if no action taken or care given.
- Trust in the person doing the triage was an important issue – trust would lead to a willingness to accept their decision about your care.
- The use of telemedicine was welcomed and it was noted that there is already some use of telemedicine locally.
- There was a lot of discussion about the value of paramedics and the suggestion that paramedics (and other Scottish Ambulance Service staff) could be connected to GP practices to create a hub and make use of all the skilled staff available.
- There was reference to the value of using ambulances and ambulance staff as part of a wider healthcare team – again, attaching teams to GP practices or surgeries and using these combined teams to make home visits with other care staff.

Young People

- To tailor the questions to young people appropriately this question was combined with question one where they were asked "How would you feel if you or a member of your family was treated by the ambulance staff and didn't have to go to hospital?" - see responses above.

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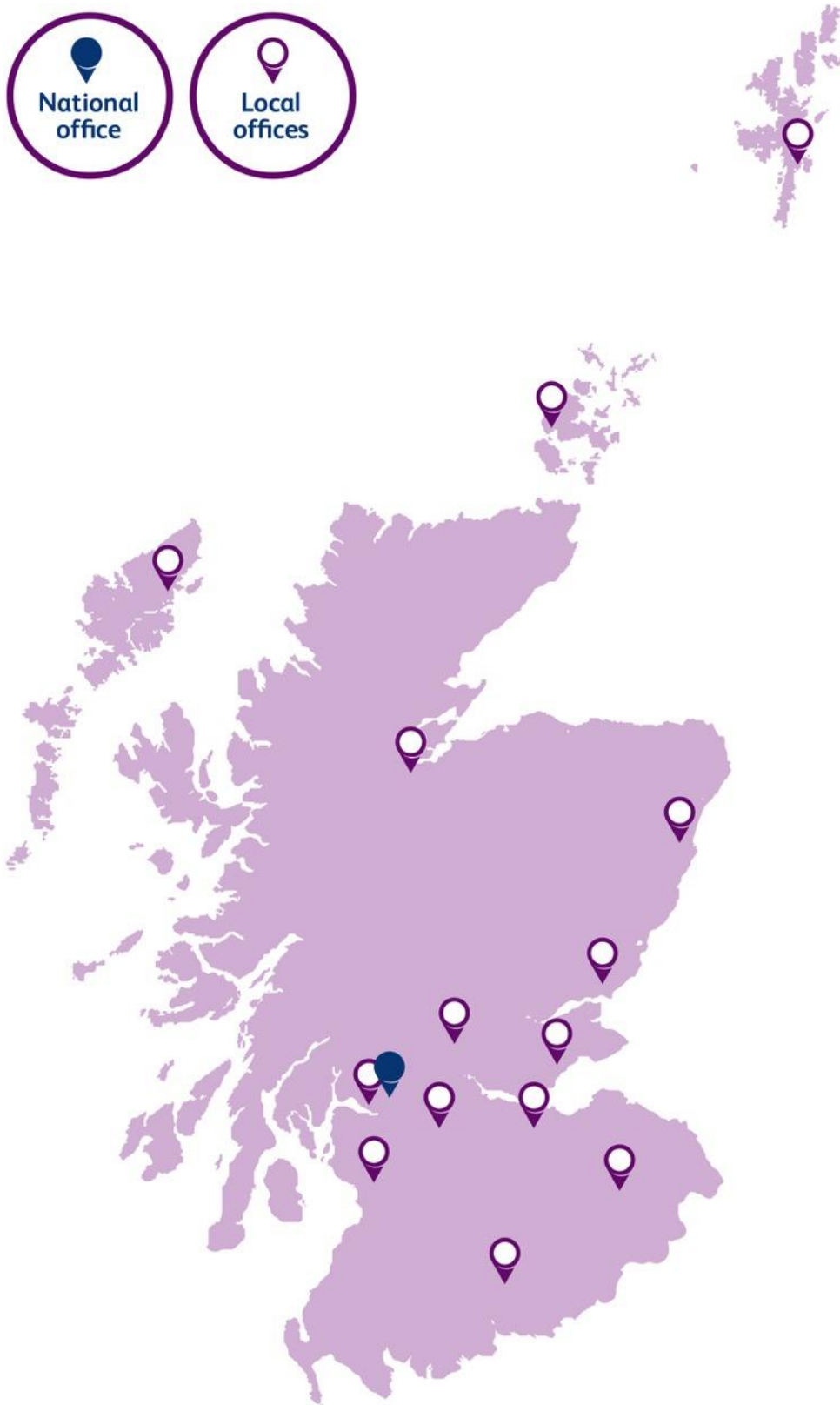
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