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The National Ambulance Review - 'Taking Healthcare to the Patient: Transforming NHS Ambulance Services' - Department of Health, United Kingdom.

- An Australian Perspective

by
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The Australian Perspective

The review, led by Peter Bradley CBE, Chief Executive of the London Ambulance Service NHS Trust in his capacity as National Ambulance Adviser to the UK Department of Health, has created considerable international interest since the report was published in June 2005.

The five year vision for the English ambulance services (Scotland, Wales and Ireland are not included), set out by the reference group and endorsed by the UK Department of Health, is not dissimilar to the strategic direction set by ambulance services that form the Council of Ambulance Authorities (CAA). The concept of working with the broader health community, patients and the public to find ways to provide better patient care more appropriately, is common to all authorities and to some extent, the findings in the report could equally apply in many areas in Australia.

However, there are significant differentials which have a bearing on some aspects of the report, and which need to be considered when making any comparison between the ambulance systems of the respective countries.

The most obvious are the vast differences in population density and distribution. Sydney, the most densely populated city in Australia at 2,075 people per square kilometre, has roughly half the population density of many English cities – *eg*. London 4,463; Birmingham 4,667; Liverpool 4,256; Manchester 3,654. In contrast, Melbourne, the next most populated Australian city has 1,519 people per square kilometre. Population density bears a direct relationship to both the demand for services and to the type of services provided – the latter being determined by political, social, economic and logistical factors.

It is the uneven distribution of population between the major centres and the vast sparsely populated areas in each state and territory of this country that is unique. The so-called "tyranny of distance" that aptly describes one of the major problems faced in serving the health needs of rural and remote areas of Australia, has virtually no application in England. Reduced (and ageing) populations in many of these communities have seen their local hospitals closed or converted into aged care facilities and the general practitioners move away, creating issues for ambulance service provision in terms of the level of care and extended travel times.

There are also significant differences in the governance and structure of the health system in the respective countries, both from a national perspective and, in the case of Australia, at state and territory level. Despite the fact that there are 31 (soon to be 12) National Health Service (NHS) Trusts governing ambulance services in England, there is national direction. A classic example of this was the 1990 edict from the UK government that there would be a paramedic on every emergency ambulance. Whereas in Australia ambulance services are a state responsibility with any national influence occurring through voluntary collaboration – albeit under the auspices of the CAA, jurisdictions establish national guidelines on clinical practice, education standards and on business issues. *"….sharing benefits in the interests of improving patient care"*.

It follows that the funding structures differ between countries and between jurisdictions within this country. The NHS provides free service to residents in England. With the exception of Tasmania, where a similar free service operates, there exists a variety of cost-to-patient systems operating throughout Australia. Hence, despite the best of intentions, opportunities for coordinated purchase of major items such as equipment, are missed or tend to be complicated by each jurisdiction's financial capability and the varying approval systems. While the structures may differ, it seems that there are some similarities in this regard.

The wide-ranging review recommends fundamental changes to improve the speed, quality and breadth of ambulance services and paramedics will be offered greater career development opportunities and more diverse roles. Peter Bradley's description of the current position in England could apply in differing degrees to most ambulance services, as all face the transition from the traditional ambulance role. Issues surrounding leadership and organisational culture, consistency of performance measurement, under-utilised potential, rising demand and inappropriate responses, are very familiar.

The proposed changes represent a shift in the role of the services to become a mobile healthcare system delivering a more personalised service to patients. This coincides with the development of the Emergency Care Practitioner (ECP) – *'usually a paramedic or nurse who has undertaken specific training and education and who is capable of assessing, treating and discharging/referring patients at the scene'*. While the benefits of the ECP concept are still to be assessed, progress of the prediction that, together with the development of improved clinical advice by telephone, attendances at Accident & Emergency Department and by emergency ambulance will be significantly reduced, it will be watched with interest.

The ECP concept appears to focus on well populated areas. In comparison, issues surounding health services in rural and remote areas has prompted the CAA to commission a research project to set strategic directions for an Expanded-Scope Paramedic role for rural ambulance services. The study will report on alternative models of ambulance practice emerging in regional and rural Australia.

UK legislation and Department of Health policy, in terms of the right not to transport certain patients and the formal registration of paramedics (read ICU paramedics) as Allied Health Professionals via the Health Professionals Council (HPC), gives greater freedom and protection than that available to Australian services.
(HPC – an independent statutory regulatory authority that sets standards for training, conduct and performance of 12 healthcare professions)

It will obviously be some time before the proposed system has all the components in place to enable these freedoms to be exercised by all the ambulance trusts. Until all the alternative

health pathways proposed in the report are in place and available around the clock, fear of litigation and/or adverse publicity may influence decisions on treatment and transport - rather be safe than sorry. This could push achieving the target of 'up to one million fewer patients facing A&E attendance' further out, although no time frame is stated.

The subject of registration of paramedics is very much alive in this part of the world. Of the CAA members, only New Zealand has a formal system in place. Governments at both federal and state level in Australia have not shown any enthusiasm for more regulatory control in this area.

The five recommendations, which expand into seventy sub-recommendations, set a huge task for a system that is endeavouring to change a culture and practice in times of increasing accountability and raised public expectations.

The conclusion reached in the report that *'ambulance services have made huge improvements over the past ten years and they are now well positioned to make a greater contribution than ever before to improving patient care'* goes without question.

The question for all of us is how to ensure that the capability and the capacity of ambulance services are recognised (both from within and outside the service) as an integral part of the broader health system.