ITEM 3 (C)

HEALTH AND PARTNERSHIPS SCRUTINY COMMITTEE

29th January, 2013

PRESENT – Councillor Newall (in the Chair); Councillors Donoghue, Francis, Macnab, Nutt, E. A. Richmond, S. Richmond H. Scott and J. Taylor. (9)

APOLOGIES – Councillor Regan. (1)

ABSENT – Councillor I. Haszeldine (1)

OFFICERS IN ATTENDANCE – Mark Cotton, Assistant Director Communications and Engagement, Paul Fell, Head of Clinical Care and Patient Safety and Barry Dews, Head of Operations, Patient Transfer Service; North East Ambulance Service NHS Foundation Trust (NEAS).

OTHER REPRESENTATIVES – Diane Lax, Darlington LINK and Kath Wall from GOLD.

HP50. DECLARATIONS OF INTEREST – There were no declarations of interest reported at the meeting.

HP51. PATIENT TRANSPORT SERVICE STRATGEY 2012 – 2017 – The Patient Transport Service Strategy 2012 – 2017 (previously circulated) offered Members the opportunity to comment on and challenge the Patient Transport Service (PTS) Strategy. Mr Barry Dews, Head of Operations guided Members through the document explaining that the Strategy sets out the vision for PTS in the North East of England and the changes that would be implemented over the next five years to achieve the vision.

Mr Dews reminded Members that PTS provides vital access to planned appointments and involves approximately one million journeys every year, has 440 staff, 232 vehicles operating from 28 stations. There are also a number of valued volunteer drivers who provide one to one transport and assistance. The core service operates Monday to Friday between 8am – 6pm for patients booked at least one day in advance of their appointment and bookings are made by medical professionals. The service also provides an urgent transport service in County Durham and Darlington for patients with an 'urgent' (non-emergency) health care need. PTS also provides transport for specialist patients such as Renal Dialysis and those services operate slightly differently than the traditional banding service.

It was noted that in Tees, the service model operates around patients' appointment times. As this system has been successful, it was planned to implement this across the rest of the North East focusing transport arrangements to be based around patient appointment times which would benefit the patients. It was explained that PTS also provides valuable resilience support to the Accident and Emergency Service and vehicles can be used to back fill if ambulances are held up at Accident and Emergency Departments.

Mr Dews outlined the main Strategic Drivers which have led to the review of the PTS and the development of the Strategy. Those being Demography (the differing needs of the population that PTS serves), Patient Choice/NHS Configuration (including Choose

and Book), Eligibility Criteria (this would have a huge impact depending on how the criteria is applied), Quality, Market Analysis/Commissioning Arrangements (variations in current contracts) and Logistics/Information Communication Technology .

Members expressed concerns about future commissioning of the PTS service and particularly that NEAS were not aware of who the new commissioners would be from 1st April 2013. It was noted that the market for PTS has grown sustainably over the recent five years and that commissioners expect ever higher quality standards that represent high value for money. Mr Mark Cotton, Assistant Director Communications and Engagement shared his concerns about future provision of PTS and the potential of other companies winning tenders for PTS for example, Voluntary Sector, Local Authority and/or Private Companies i.e. Arriva. Mr Cotton reported that Arriva have been awarded the contract for PTS in Greater Manchester and advised that NEAS has recognised the potential of competition and are focused to ensuring that the PTS they provide is robust and cost effective to withstand competitors. The benefits of ambulance services providing PTS enables them to treat patients if an emergency situation arises and avoids the need for an additional ambulance and provides flexibility and adaptability to the service.

Particular reference was made to cancelled or aborted journeys and Members were surprised to note that 20% of journeys are aborted because the patient is not ready. Journeys are also aborted because patients have already been admitted to hospital, are too ill to travel, patients are still waiting to be discharged or for medications or remaining in hospital. NEAS are keen to work with Acute Hospitals to be part of the Discharge Policy and consideration is being given for electronic communications for when patients are ready for collection.

Mr Dews summed up by explaining that PTS as a service is changing to be able to compete in the market by providing a more efficient and effective service. All aspects of the services are being included such as consideration has been given to overnight storage of ambulances and whether providing a central garage to store ambulances rather than having a spread of depots across the Region would be more cost effective. Consideration is also being given to staff garaging ambulances at home. This would obviously be more efficient if NEAS are only paying rent for a small number of depots rather than a vast number.

Members welcomed the discussion and forward thinking of NEAS and offered their support if any way they could. Members see the value in NEAS providing PTS and agreed that streamlining the service and running transport based around appointment times would greatly benefit patients, patient opinion and patient choice and ultimately increase the volume of the service overall.

RESOLVED – That the Strategy be welcomed and the information be noted.

HP52. STROKE SERVICES –Paul Fell, Head of Clinical Care and Patient Safety introduced a PowerPoint presentation addressing the four key concerns that Members had previously raised in respect of stroke services. Members had raised concerns around delays in transfers from Darlington Memorial Hospital (DMH) to University Hospital of North Durham (UHND); stroke patients to the stroke unit, who makes the decision to take a patient to the stroke unit and future recording of stroke outcomes.

Mr Fell explained that a number of people with stroke symptoms often self-present to the Accident and Emergency Department at DMH or have a stroke on the Ward in DMH and are transferred to UHND. It was acknowledged that there has been a delay in moving patients. The issue for NEAS has been the handover on arrival at hospitals and Mr Fell added that this had been recently reported in the press. He acknowledged that ambulance crews have recently been waiting over two hours in a queue to hand the patient over to hospital staff and this has a knock on effect the other ambulances and transport provision. He reported that the Chief Executive of NEAS was hosting a Clinical Summit and inviting all Chief Executive of Acute Hospital Trist to attend to discuss addressing this on-going issue. It was acknowledged that GP also play a role in this and that all NHS organisations needed to be involved to resolve the matter.

In response to a question, Mr Fell explained the process from a 999 telephone call for a patient with a suspected stroke. Members acknowledged that the paramedic on arrival would assessment the patient to ascertain whether the symptoms presented as a stroke. If it is determined that the patient has suffered a stroke then the paramedic would make contact with the stroke unit at UHND to establish whether they can accept the patient, if they can not the patient would be taken to DMH. This could be due to a whole host of reasons, including bed occupancy levels, clinical reasons, etc. If Paramedics are unable to conclude a stroke has occurred the patients would be transported to the nearest Accident and Emergency Department for further assessment. Members expressed concern that the stroke unit did not accept all suspected stroke patients and Mr Fell offered to carry out an audit on the frequency that situation arose.

It was reported that the window for Thrombolysis had very recently been extended to five hours and therefore this could account for the rise of the number of stroke patients together with earlier identification of symptoms. Members acknowledged that paramedics make an initial diagnosis but accept that the ultimate decision about who is admitted to the stroke unit is made by staff from within the stroke unit.

Members expressed concerns about ambulances queuing outside hospitals and welcomed the Clinical Summit as a start to address this issue. Mr Fell acknowledged that having ambulances waiting in queues puts pressure on the Accident and Emergency Services. He added that NEAS has seen a 7% increase of workload each year and these pressures place an additional strain the numbers of vehicles active at any one time. Centralising services to a central location also has impacted of ambulance travel times and delays in handovers at Centres of Excellence merely exacerbate this issue.

Mr Fell reported that the introduction of the Hospital Ambulance Liaison Officer (HALO) has assisted in some prevention handover delays and has tried to ensure that there is a quick and smooth turnaround. The post has had mixed success and the grade of staff has been an issue as matters were still having to be referred to Assistant Director/Director level to be resolved more promptly.

Mr Fell proudly reported that NEAS number on the UK for getting suspected stroke patients to a dedicated stroke unit within an hour and in the top three nationally for correct assessment on the scene by paramedics. Members were delighted to hear this and suggested publicising this success widely.

Mr Cotton invited Members to submit any specific incidents to him where ambulances had been delayed or there have experience of ambulances cuing outside Accident and Emergency Departments.

RESOLVED – (a) That the presentation be noted.

(b) That the Head of Clinical Care and Patient Safety undertake an audit of reasons why patients are not admitted to the Stroke Unit if they are assessed to have suffered from a stroke and that the report be brought before Members of this Committee for consideration in due course.

HP53. OVERVIEW OF THE ROLE OF PARAMEDIC – Paul Fell, Head of Clinical Care and Patient Safety introduced a PowerPoint presentation which provided an overview of the role of the Paramedic. Members were reminded that Paramedics have the ability to autonomously assess and diagnose; provide assessment of patients; are able to handle and administer drugs and controlled drugs; can undertake invasive procedures, such as intravenous cannulation, intubation, needle thoracocentesis and external jugular cannulation and cardiac interventions for example manual defibrillation, 12 Lead ECG recognition, interpretation and treatment including the diagnosis of myocardial infarction.

Mr Fell explained that trauma is only a minor element of a Paramedics work load and the majority in medical based. There are currently 30 Enhanced Care trained Paramedics who are able to close wounds, treat chest and urine infections and make clinical judgements and not necessary transport a patient to hospital, if they can be treated at home. Paramedics in rural areas are commissioned to provide support to wellbeing clinics and GPs and also carry out visits on behalf of GPs and urgent care visits. The Trust would like to move towards proving more Enhanced Care Paramedics to provide a more holistic service but this would be a decision for the the commissioners. It was noted that Paramedics are not currently able to prescribe medications but the College of Paramedics are campaigns to enable them to do so.

In response to the question Mr Fell explained that Emergency Care Support Workers and Technicians have their roles within ambulances and rapid response vehicles and they are work well as a team. The recent Accident and Emergency Review of the services streamlined the number of crews and vehicles to provide a more efficient and effective service.

Members welcomed the presentation and found the whole discussion extremely informative and were delighted to be invited to experience going out with a Paramedic in an ambulance.

RESOLVED – (a) That the presentation be noted.

(b) That all the Officers be thanked for their attendance at the meeting.