HEALTH SCRUTINY COMMITTEE

Minutes of the meeting of the Health Scrutiny Committee held on Monday, 14th November 2011 at 6.00 p.m. in the Civic Offices, Telford, Shropshire

PRESENT:

Councillors D. White (Chairman), V. Fletcher, J. Seymour, C. Turley. Scrutiny Co-optees, D. Davies, R. Shaw.

Also Present: Craig Cook, Assistant Chief Officer - Resilience and Support Services Manager, WMAS; Daren Fradgley, Assistant Chief Officer Head –Performance Improvement, WMAS; Matt Bennett, DoS lead officer for the West Midlands; Dean Jenkins, General Manager; Stephanie Jones, Scrutiny Group Specialist.

HSC-11 MINUTES

The minutes of the previous meeting held on 22nd September 2011 were agreed as an accurate reflection of the meeting and signed by the Chairman.

HSC-12 APOLOGIES FOR ABSENCE

None

HSC-13 DECLARATIONS OF INTEREST

None

HSC-14 WEST MIDLANDS AMBULANCE SERVICE (WMAS) MAKE READY SYSTEM AND NHS PATHWAYS

1. MAKE READY

Craig Cook, Resilience and Support Services Director, WMAS gave a presentation on the Make Ready System for Telford & Wrekin.

The presentation highlighted the following points:

- Key data for Telford & Wrekin:
  - Population 169,000
  - Ambulance activity (incidents attended) 24,000 p.a.
  - Category A8 performance 83.8%
  - Category A19 performance 99.1%
  - Patients taken to hospital 16,000
  - Operational A&E vehicles 22
  - Operational staff 97
  - Community first response schemes 3

- Make Ready is a quality assurance vehicles and equipment preparation programme aimed at improving efficiencies across the whole service. Currently, the paramedic crew checks the vehicle, equipment and drugs when they come on

duty. With Make Ready, there would be a team of Ambulance Fleet Assistants who would clean, re-stock and carry out checks on medical devices and vehicles ready for when paramedics come on duty.

- Make Ready goes alongside a review of estates and the distribution of ambulance stations. There were currently around 70 stations across the region with around 20 staff per station. Staff would be grouped around fewer hubs (with community stations and ambulance stands) to allow greater flexibility to focus resources on peak activity periods and places.

- An analysis of patient flow in the county showed a roughly equal flow of patients to PRH and RSH. The model was flexible to take account of the acute hospital reconfiguration.

- An analysis of life-threatening emergencies across the county showed high concentrations around Telford and Shrewsbury, smaller pockets around Oswestry and Whitchurch with other emergencies scattered across the county.

- There were currently 8 ambulance stations in the county with 2 (Donnington and Tweedale) in Telford & Wrekin. There would be investment in the structure of the hubs. Post Make Ready there would be 2 hubs in the county (Shrewsbury and Donnington) with four community ambulance stations in Telford & Wrekin (Tweedale, Stafford Park, Wellington and Newport) and 2 more over the border in Bridgnorth and Market Drayton. Locations had been mapped against emergency activity so ambulances would be stationed to respond more quickly as accidents present, within 8 minutes of anywhere in the borough.

- Ambulance Fleet Assistants would be employed to prepare ambulances and equipment for when crews come on duty. On average, one hour of a twelve hour shift is taken up with logistical issues and passing this to auxiliary staff would mean there is 100% paramedic availability and no lost clinical time.

- The benefits of Make Ready were summarised as:
- Improved response needs and times
- Meet the needs of the oatient (“right time, right place, right care”)
- Improved patient outcomes
- Reduced waste and increased efficiency

Following the presentation members asked a number of questions.

Is there still full service coverage under the current system during the time that ambulances are being prepared?
Under the present system the crew may be called out before all the necessary checks have been completed so it is more difficult to ensure the service. Make Ready will free up paramedic staff from logistical tasks and ensure there are 12 hours of clinical time for each 12 hour shift.

12 hours is a long shift especially when crews can have shifts extended by out of area journeys – is there a problem with fatigue?

12 hour shifts are optimum for operational service needs and staff have expressed a preference to work longer hours for fewer days per year. There are varying shift patterns which conform with EU working time directives and a managed rostering system. The control room runs on protocols so there is a constant swap-over of crews. If a crew ends a shift at a hospital which is bed blocked, a relief crew is sent out to take over so the crew can go home. Crews are not deployed on long distance transfers when they are nearing the end of their shift unless there is a clear need. The introduction of the hubs and centralisation of staff will mean that shifts can be rostered more efficiently to reduce these kinds of extensions to shifts.

Is bed blocking still an issue for ambulances at PRH?
There is still a problem. Other areas have Hospital Ambulance Liaison Officers (HALOs) so there is a hospital based paramedic to monitor the actions required to keep patients arriving by ambulance flowing until a bed becomes free so that the ambulance can return to operational service and is not tied up at the hospital. Telford & Wrekin PCT funded a HALO for 18 months but then decided to discontinue the funding.

Is there any cross-over of crews between areas e.g. for transfers between PRH and Newcross?
Generally a Telford crew would transfer patients from PRH out of area. But if it is very busy the control room could ask a black country ambulance to pick up. It would depend on the priority the hospital has given to the patient. If a patient is stable, there is usually a 4 hour window to transfer but some cases may be more urgent.

How is the service prepared for a major accident such as seen recently on the M5?
The service is strongly placed to deal with a major incident. Anthony Marsh, the West Midlands Chief Executive, leads on emergency response nationally and there has been heavy investment in specialist training and equipment to respond to major accidents. Protocols are in place to manage the accident scene, especially during the initial crucial stages. The control room would be able to deploy resources from other areas very quickly. The Hazardous Accident Response Team are specialists who work with the fire service and would work between an area of danger such as chemicals or fire and safe areas. The team is based in Oldbury, about 40 minutes from Telford.

Do the hospitals pay for the ambulance service?
The ambulance service is commissioned annually by the PCT and is separately funded from the hospitals. There is provision in the funding arrangements for variations of service. In Telford & Wrekin there is also a private contractor to move patients between hospitals, but if the patient needs a higher level of care this would fall to the ambulance service.

I am pleased to hear about the upgrading of paramedic skills. How does the advanced paramedic skill level compare to a nurse or doctor?
The NHS has introduced a new nurse/paramedic practitioner level which is between doctors and nurses. The advanced paramedics have more responsibility and power. They are state registered by the professional health care council and are responsible for their own continuing professional development. Training modules are based around 3 key areas:

- Assessment of conditions and systematic critical protocols
- Treatment - e.g. wound treatment, drug treatment
- Discharge - checking there is adequate onward care e.g. referral back to the GP or other part of the health system.

Currently 35% of patients are not taken to hospital and the advanced paramedic training should reduce the need for hospital admissions further. The discharge training will ensure patients not taken to hospital have a route back into the system. There is also a clinical desk at Brierley Hill which paramedics can call for advice. The Trauma review will provide more on-line clinical care from doctors.

How do you make sure patients not admitted to hospital have a route to further help should they need it?
35% of patients are not taken to hospital. Sometimes, the problem is dealt with on the spot, for example a diabetic event, and there is no need for hospitalisation or further treatment. Patients are always advised that if they have further problems they should call 999 again. GPs are advised about such events. The patient is given a copy of the ambulance report and advised to take it to their GP.

How many Fleet Assistants will there be and how will they be funded?
There will be 11 Fleet Assistants in Shropshire financed from reduced overheads resulting from the modernisation of buildings. There is no new money available.

When will the Donnington hub open?
It will be running from around April 2012. There is building work, the reorganisation of the operation and staff consultation to do before the system can go live. The original Make Ready plan was for one hub for the county in Shropshire, but a number of factors and the identification of additional savings influenced the decision to have a second hub in Donnington.

Are many 999 calls made because patients cannot contact their GP?
There are no statistics on this as all calls are responded to, and paramedics assess the situation based on what they find. The Directory of Services system will allow us to gain more intelligence about patient flow.

What is the average wait time for ambulances at RSH and PRH and is there still an issue with bed blocking?
Much work has been done to improve patient flow, but there is still work to be done.

Do the Hospital Ambulance Liaison Officers (HALOs) make a difference and offer value for money?
A paramedic must stay with a patient in hospital until they can be handed over to hospital staff. This means the crew and ambulance can be out of action for hours if beds are blocked. The problem is more acute in rural areas where a small number of ambulances out of commission has a big impact. The HALOs work with the hospital management team to improve patient flow and ambulance turn around times. In 2010 Shropshire and Telford & Wrekin PCTs funded HALOs for 18 months but the funding was not renewed. It takes time to improve the system, but other areas which have maintained the HALOs are seeing improvements. Hartlands hospital has turned around performance. In October there was a lot of activity in the West Midlands and

ambulance delays, so front line staff were deployed to act as HALOs at PRH and RSH. The HALO was able to stay with patients in the hospital so that the ambulances could be turned around quickly which made a difference.

Actions agreed:

- **Information about wait times at PRH and RSH would be provided to the Committee.**

- **Comparative data on ambulance turn-around times would be provided for hospitals with and without HALOs.**

- **West Midlands ambulance performance monitoring information would be provided to the Committee on a regular basis.**

2. NHS PATHWAYS

Daren Fradgley, Head –Performance Improvement gave a presentation on the NHS Pathways & Capacity Management System Directory of Services (CMS DOS).

This CMS DOS system was being implemented to route 999 calls to the appropriate NHS service so that patients go to the "Right Place, First Time, All of the Time".

There had been an increase in ambulance activity with a growing number of 999 calls. 999 is often seen as the easiest and quickest route to access NHS services. It is well recognised, easy to remember, and people feel familiar with the service from hospital dramas on TV. The majority of 999 calls are now for non-life-threatening situations, so the ambulance service no longer deals exclusively with emergency care, but also deals with non-urgent care. To this end the service must evolve and route these patients more appropriately.

There were 810,000 999 calls in the West Midlands in 2010. The number grows by around 4-5% each year and calls are projected to increase to over 1million over the next five years. Funding will not increase with the level of activity.it is also an opportunity to make the system more efficient.

Ambulances are currently dispatched to 96% of all calls. To maintain neutral growth of the service, the number of calls not dealt with by ambulance response will need to increase from 4% this year to 8% in 2012, 12% in 2013 and 20% overall over the next 5 years.

The NHS Pathways / CMS DOS system was being implemented to make clinical assessments of calls so that non-life-threatening calls could be directed to the appropriate NHS provider to respond. The previous position was that 999 calls were "triaged" to determine whether the call was life-threatening, potentially life-threatening or non-life-threatening. In practice, ambulances responded to 96% of all calls so the triage system was not effective. 68% of ambulance call-outs resulted in hospital admission when only around 20% of the calls required an emergency response.

Work had been done with health partners to build up a Directory of Services (DOS). DOS is an internet tool which maps all health care provision within each geographical area, including GPs, primary care providers (walk in centres, community nursing etc.) and brought together in one place. The intention was to extend the directory to include local authority services over time.

With the CMS DOS system, 999 calls would be assessed to identify life-threatening signs and symptoms. Life-threatening calls would be red flagged and an ambulance would be dispatched immediately. Non-life-threatening calls would be assessed using the model sitting in the DOS to match the need against the right service provider and calls would be routed to that provider. The intention is to get patients into the primary care system at the right point, or to offer self-help. If there is no match in the DOS system, the patient moves to the clinical support desk which is staffed by clinicians, advanced paramedics and paramedics for further investigation. If there is any doubt about the symptoms, the patient receives an emergency response. Response times though DOS would range from immediate to 72 hours depending on the service required and level of urgency.

The intention was to make the directory available to all health care providers, private providers and the public. Access to parts of the system would be restricted

The key benefits of the system were highlighted as:
- Patients go to the right place, first time all the time
- Improved patient journey and experience
- Better use of available resources
- Cost base for assessment and referral to care much reduced
- Inappropriate ambulance journeys avoided
- Reduction in 999 conveyances and A&E attendances
- Gives commissioners world class data on what services are needed.

CMS DOS had been extensively piloted in 4 sites with 1.3 million 999 and 111 calls assessed with no adverse events. 6.6% of calls had been dealt with in the Directory or Clinical Support Desk (an improvement from 4%). The system was clinically driven with oversight by the National Clinical Governance Group chaired by the Royal College of GPs, had been academically evaluated by 2 universities and has overt suppor from the BMA and Royal Colleges.

In Telford & Wrekin since 20th September there had been 1747 emergency calls with 1647 emergencies. Of the emergencies, ambulances had responded to 1806 incidents, 35 calls were referred to GPs, 9 to the Clinical Support Desk, 7 to self-directed help.

The implementation of the system in Telford & Wrekin had taken longer than expected because GPs had requested more consultation before going live. The system had been implemented in a staged approach, but all parts were now ready to go live. All GPs, the community nursing team, midwifery unit, emergency practitioners, clinics and community services and out of hours services were in the Directory.

Following the presentation, members asked a number of questions.

Who will answer the 999 calls?
The existing staff will be taking the calls with the new system. They are trained in robust questioning techniques and use a repetitive assistance model to get the right information without wasting time. The module is time limited so the response is fast. If there is any doubt about the situation, an ambulance is dispatched. If the call is identified as a non emergency, the call moves onto the assessment model in DOS to match symptoms to the appropriate service.

How will you ensure that the patient receives a response when they are referred to an alternative provider, for example for a GP appointment?
The ambulance service will notify the GP that the patient has been assessed through the system to ensure that the GP sees the patient. Patients are always advised to call back if they do not receive a response.

Would the person dealing with the call contact the appropriate provider themselves, or would the patient contact them?
If there is an established relationship between the patient and the provider (for example their GP) the patient would be expected to contact the provider themselves. However, they would be given a timeframe for making contact and advised to call the ambulance service again if they have not succeeded in making contact within that timeframe. If there is no existing relationship between the patient and the provider, the Ambulance Service would contact the new provider.

If the system cuts costs for the hospital, should they contribute to paying for the system?
We are working with the PCT and Clinical Commissioning Group on the system. The GPs are very supportive and the Chairs of the Clinical Commissioning Groups in Telford & Wrekin and Shropshire have been championing the system regionally. The directory has focused on primary care, but the aim is to work with the local authority to extend care services in the directory.

Other questions;

Is WMAS continuing to work with SaTH on the hospital reconfiguration?
Work is on-going at a commissioning level and with local management to ensure plans support the reconfiguration and ensure the service is right for patients. We are doing this in conjunction with the Welsh Ambulance Service.

Actions agreed:

- **That copies of the Health Economy Information Leaflet on the NHS Pathways and Directory of Services provided by WMAS would be distributed to staff in adult and children's care services. The leaflet was aimed at health providers.**

- **That once information for the public was available there would be a link from the Council website to this information.**

- **That a visit would be organised for members to visit the control room to see the Directory of Services in operation.**

The Chairman thanked WMAS officers for attending the meeting, presenting the information and answering the Committee's questions.

HSC-15 NATIONAL AUTISM STRATEGY

This item was deferred to a future meeting as apologies had been received from the Development Manager Autism West Midlands.

HSC-16 FORWARD PLAN

There was a discussion about the Forward Plan and the following was agreed:

- That the Committee would not include the Trauma Review in the work programme as the designation of RSH as the trauma unit for life-threatening trauma was part of the reconfiguration proposals and was a matter for the Joint Health Overview & Scrutiny Committee.

- That the next meeting would be to look at the development of the Health & Wellbeing Board, including the development of the Joint Strategic Needs Assessment, and the development and support for the Clinical Commissioning Group.

- That the Community Trust should be invited to address issues for Telford & Wrekin. Clarification should be provided about responsibilities for commissioning and providing services based in the community.

The meeting ended at 8.15 p.m.

Chairman: .....

Date: .....