Agenda Item 4

Great Western Ambulance Joint Health Overview & Scrutiny Committee

Friday 18 April 2008 at 11:00

The Council House, Bristol

Present

Councillors: Lesley Alexander (Bristol City Council), Sylvia Townsend (Chair for this meeting only), Bill Payne (Bristol City Council), Deryck Nash (Cotswold District Council), Reyna Knight (North Somerset District Council), Ann Harley (North Somerset District Council), Anne Kemp (North Somerset District Council), Sandra Grant (South Gloucestershire Council), Roy While (Wiltshire County Council), Paula Winchcombe (Kennet District Council), Andrew Bennett (Swindon Borough Council), Margaret Nolder (Gloucestershire County Council), Shirley Holloway (South Gloucestershire Council)

Others: Tim Lynch, Rachel Pearce, Steve West (Great Western Ambulance Trust), Zoe Wilkins (South Gloucestershire Council), Norman Cornthwaite (Bristol City Council), Richard Thorne (Gloucestershire County Council), Emma Powell (Swindon Borough Council), Jo Howes (Wiltshire County Council)

Public Gallery: Councillor Anthony Clarke (Bath & North East Somerset Council), Jan Stubbings, Hazel Braund (Gloucestershire Primary Care Trust), Victoria Eld, Chris Marsden (Great Western Ambulance Trust)

10. Apologies for Absence

Andrew Gravells
John English
Margaret Edney
Peter Mallinson
Ray Ballman
Andy Perkins
Sue Hope

11. Declarations of Interest

Councillor Reyna Knight, Chair, Jubilee Daycare Centre

12. Public Forum

No members of the public had asked to speak.

13. Minutes of the Previous Meeting

On page 3 it was agreed the date at the bottom of the page should read 2007 and not 2008.

It was resolved to:

Circulate the minutes of the GWAS Trust Board to members of the Joint Scrutiny Committee.

14. Review of Great Western Ambulance Trust Performance

There was a query about 19 minute Category A target time. The Committee was informed the target is for all ambulance trusts to respond to 95% of category A calls within 19 minutes after a request has been made for transport.

Steve West (SW), Director of Operations, gave a short presentation on the Trust's performance over the last month.

Performance across the patch has continued in the same vein as the previous month with Gloucestershire showing sustained improvement, Avon sustained at a target-hitting level and Wiltshire still challenged. The new methodology needs to be embedded before consistent improvements can be shown.

Call Connect was launched on 1 April, taking 90 seconds off of the initial response time as it is now measured from when the call is connected.

Across the Trust area 59 new Emergency Care Practitioners (ECPs) have been appointed and adding this level of care into the skill mix will help to address the problems thrown up by Call Connect.

There was a general discussion during which added further clarity and confirmed that:

North Somerset is included in the Avon sector.
The software helps operators to assess calls as they talk to patients and callers on the phone and it is risk averse. The Trust is intending to adopt a different system that will offer further improvements during the next 2 years.

There was discussion about how to achieve consistent improvement across the entire area, given that there are rural areas in Gloucestershire and Avon that are showing better results than rural Wiltshire. The performance standards had never been delivered previously consistently in Gloucestershire, but now this has been achieved the Trust is confident the same can be done for Wiltshire within the next 6 months.

It was stated that new technology makes the performance data more transparent and is the key to delivery in rural areas, but the Trust will have to work in partnership with the rest of the NHS to develop more effective systems in rural areas.

Patient Handover was discussed, in particular as the delay times vary from hospital to hospital. SW confirmed there are action plans to improve performance in certain areas and the Strategic Health Authority is supporting a peer review. Work is ongoing and there is now ownership and a willingness to resolve the issue which is a significant shift. Tim Lynch (TL), Chief Executive of the Trust described the tension between ambulances waiting outside A & E and acting as a buffer for that service against the impact on the health economy of having ambulances out of the system and again the development of ECPs will help to resolve some of these issues.

The Trust wants to change some of its procedures that would have a positive impact on hospital turnaround times, but will need to go through appropriate public engagement in order to do this.

TL spoke about response times and appropriate levels of response. For instance, if a GP has booked an ambulance to take a patient to hospital it might appropriately arrive one or two hours later for non emergency cases. At the weekend the available responses are adapted to meet the particular need, but there are not a set number of vehicles available in certain areas, the service is flexible and vehicles move around as necessary.

It was resolved that:

GWAS would provide information about the number of units located in each district and the type of vehicle – NB. This will be a snapshot in time as vehicles are constantly moved to meet demand.

Information about GWAS drive zones that was received at the February meeting would be circulated.

15 Staff and Training

TL explained that the workforce plan is for five years, so although it appears that the Trust is understaffed currently, in fact there are only 25 full time staff vacancies and this year 266 new people have been employed.

As a rough guide it is estimated that a new employee can reach paramedic level within three years, but this is seen as inefficient and staff are now taking in a foundation degree which offers a similar level of qualification to the RGN qualification for nurses.

Staff are now group in 85 teams of no more than 10, so they have greater input in how they are rostered and training is built into this. There is a new Occupational Health contract to offer support to staff.

The Trust is interested in tapping into Local Authority experience in order to address the diversity agenda. There are some cultural groups who do not see the ambulance service as a job for them. Members agreed that Local Authorities could offer help and guidance to the Trust on this matter.

The Trust is actively addressing the issue of staff appraisals and personal development plans.

It was resolved that:

GWAS would provide details of the 5 year plan for establishment levels and skill mix

A representative from GWAS HR would be invited to the next meeting of the Joint Committee.

GWAS would provide information about how it proactively promotes positive action in relation to recruitment.

The Joint Committee would recommend that local authority HR departments are encouraged to liaise with GWAS HR team to assist in local recruiting through job fairs, etc.

The next GWAS Performance Report would include details of mandatory training.

The members of the Joint Committee (the individual HOSCs) would support the Trust by cascading information about the service and potential for community involvement through to communities and the public.
The Joint Committee would discuss the role of ECPs within the wider health economy when it meets with PCTs later in the programme.

A visit to a control room would be arranged.

GWA would provide information about the maintenance of ambulances.

16. Community First Responders

CFRs are lay volunteers who receive training in order for them to respond to life threatening heart calls, particularly in the country. The are trained to identify and treat patients with defibrillators, the system is very safe and the machine won't shock the patient unless they are in cardiac arrest.

There are 64 CFR teams across the Trust area made up of 221 individuals. They do not attend any calls involving children or trauma, alcohol, violence or mental health. The idea is that they respond within a tight drive zone, ideally walking or trotting distance and they are paged or called on a mobile.

CFRs have to be over 18, meet certain physical criteria, follow a code of conduct, pass CRB checks, be trained and retrained and sign an agreement. They are either on or off call.

There is a governance framework and CFRs are taught to back away from a situation if it feels wrong. GWAS is strict about what type of emergency CFRs can be sent to and they are ideal for rural areas where demand is not high.

GWAS is keen to use Local Authority links, through Parish Councils, etc, to spread the word and continue to build up CFR schemes.

There are funding issues for CFR schemes because there is no centralised core funding. GWAS helps where it can to get schemes launched, but the main source of funding is PCTs. Communities themselves often raise money and Parish Councils tend to be supportive.

It was resolved that:

GWAS would provide information on areas where more CFRs are needed.

The Joint Committee would work with the area managers for CFRs in each sector to help promote the role of CFRs in each local authority area.

17. Annual Healthcheck

Rachel Pearce, Director of Corporate Development for the Trust gave an outline of the declaration that the Trust would be making to the Healthcare Commission for the year 2007/08. The Trust will be declaring non compliance with 9 standards where it has not met targets. This represents significant progress for the year although there is still a great deal of work to do to improve performance for the 08/09 period.

The individual scrutiny committees made a variety of comments and the key themes are captured in the paper that was circulated to members, including:

Unnecessary journeys to hospital
Hospital handover times
Rapid response vehicles
Staff sickness and vacancies
Communications
Community First Responders

It was resolved that:

Individual HOSC commentaries would be collated and common themes used for further review by the Joint Committee.

GWAS would forward new PALS literature for circulation to the Joint Committee.

18. Review of Work Programme

There was a discussion about the planned visit to an Ambulance Station and it was agreed that, because of the potentially large numbers of members and officers attending, the visit would be split into possibly three groups, one of which would go to the control centre at Almondsbury in Bristol.

How to involve patients and the public in the work of the Joint Committee was also discussed and TL offered to provide contact details for the Patient & Public Involvement members who are involved in the Trust Transformation Programme until such a time as the Local Involvement Networks are up and running.

It was resolved that:

The ex-PPIF members who have been invited to participate in GWAS Lay Forum will be invited to attend a future meeting of the Joint Committee.

19. Merger of PTS Controls to Almondsbury, Bristol

The Chairman agreed to take an extra item from the Trust on the day. A letter was circulated outlining plans to merge the control function to one site at Almondsbury in Bristol. Members were told that this is a managerial move and will not affect the service offered to patients.

There are 17 contracts with the various acute trusts, although some are being re-tendered. This is not being seen as a significant change, although it must be

recognised that the duty to decide whether or not a change is significant rests with Overview & Scrutiny Committees. Some staff are happy and some are not, but the Trust believes the change will have a positive impact on efficiency.

Date of Next Meeting – 23 May 2008 at Wiltshire County Council