Agenda Item 4

Great Western Ambulance Joint Health Overview & Scrutiny Committee

Friday 30th October 2008 at 11.00

North Somerset Council, Committee Room 2, The Campus, Highlands Lane, Locking Castle, Weston-super-Mare, BS24 7DX

Draft Minutes (Version 2 Updated 27/11/08)

Present

Councillors: Andrew Gravells (Chairman) (Gloucestershire County Council), Lesley Alexander (Bristol City Council), Bill Payne (Bristol City Council), Margaret Edney (Cotswold District Council), Brian Oosthysen (Gloucestershire County Council), Sue Hope (South Gloucestershire Council), Sylvia Townsend (Bristol City Council), Andrew Bennett (Swindon Borough Council), Peter Mallinson (Swindon Borough Council), Councillor Sandra Grant (South Gloucestershire Council), Roy While (Wiltshire County Council), Ann Harley (North Somerset Council), Anne Kemp (North Somerset Council) Reyna Knight (North Somerset Council)

Others: Emma Powell, Scrutiny Officer (Swindon Borough Council), Caroline Pickford, Scrutiny Officer (Wiltshire County Council), Anthony Marsh, Interim Chief Executive (Great Western Ambulance NHS Trust), Tamar Thompson, Interim Chief Operating Officer (Great Western Ambulance Service NHS Trust), Norman Cornthwaite (Bristol City Council), Alix Boswell, Scrutiny Manager (Bath and North East Somerset Council), Debbie Freeman, Scrutiny Officer (North Somerset Council), Duncan Thomas (Gloucestershire Primary Care Trust), Victoria Eld (Great Western Ambulance NHS Trust), Margaret Adams (Great Western Ambulance External Reference Group and Bristol LINk), Mervyn Monks (Great Western Ambulance External Reference Group and South Gloucestershire LINK), Jill Crooks (Wiltshire Gazette and Herald), Vicky Methanis (Bristol Evening Post), John Penrose MP (MP for Weston-Super-Mare)

49. Apologies for Absence

Councillor Andy Perkins, South Gloucestershire Council
Councillor Ray Ballman, Swindon Borough Council
Councillor Judy Seager, Wiltshire County Council
Councillor John English, Wiltshire County Council

50. Declarations of Interest

No declarations of interest were made.

51. Public Forum

Mrs Margaret Adams (Great Western Ambulance External Reference Group and Bristol LINk) asked:

"Whether Primary Care Trusts were being put under increased pressure to make use of Emergency Care Practitioners (ECPs) in community settings."

Mr Anthony Marsh, Interim Chief Executive Great Western Ambulance NHS Trust commented that ECPs do an excellent job and that their primary role should be to respond to 999 calls so that they can treat people in an appropriate manner in their own homes. It is important that they work closely with Minor Injury Units (MIUs) and other primary care services but this must not impact on their ability to provide an emergency response.

Mr Mervyn Monks (Great Western Ambulance External Reference Group and South Gloucestershire LINK), asked:

"If the Committee was aware of the recent "Treatment of heart attack national guidance: Final report of the National Infarct Angioplasty Project (NIAP)" that has been published by the Department of Health and what steps are being taken by the Great Western Ambulance NHS Trust to respond to this guidance."

Mr Marsh responded that the Trust is aware of the national impetus to improve cardiac care and that the Trust is implementing an extensive programme regarding thombolysis. Duncan Thomas, Gloucestershire Primary Care Trust (PCT), added that the Avon, Gloucestershire, Wiltshire and North Somerset Cardiac Network is considering how best to roll out the primary angioplasty strategy across the region.

It was resolved that:

- **That the Great Western Ambulance NHS Trust would provide a summary regarding the provision of primary angioplasty** (Response attached at Appendix 3)
- **That Duncan Thomas provides an update regarding the recommendations of the Avon, Gloucestershire, Wiltshire and North Somerset Cardiac Network in relation to the roll out of primary angioplasty across the region** *(Response attached at Appendix 2)*
- **That Emma Powell would circulate *"Treatment of heart attack national guidance: Final report of the National Infarct Angioplasty Project (NIAP)"* to members of the Committee**

52. Opening Remarks by the Chairman

The Chairman welcomed Anthony Marsh to his first meeting of the Committee.

53. Minutes of the Previous Meeting and matters arising

The minutes of the previous meeting held on 26th September 2008 were agreed as an accurate record.

54. Transformation of Great Western Ambulance, Anthony Marsh, Interim Chief Executive Great Western Ambulance NHS Trust

Anthony Marsh thanked the Committee for inviting him to attend the meeting.

Mr Marsh advised the Committee of his role at GWAS as follows:

- His background is in transforming challenged organisations and he has been successful in significantly improving the performance of Essex and West Midlands Ambulance Trusts
- His role with GWAS is to support the Trust whilst a recruitment process is carried out to appoint a permanent Chief Executive
- GWAS has already made a lot of progress in moving forward and this process needs to be accelerated
- Supporting all staff across the organisation to make a difference to patients

Mr Marsh summarised his vision to take the organisation forward:

- Leadership in the organisation – visible leadership, setting clear and ambitious goals for taking the organisation forward
- Grip – Having a clear understanding of the organisation and its priorities and ensuring that assets and resources are aligned accordingly
- Confidence and credibility to deliver against priorities – this includes being clear about what work will and will not be progressed at this time, for example several transformation projects have been suspended, and building a sense of achievement and success

The aim is to provide sustained delivery of all national targets across all areas served by the Trust. Although GWAS covers some large rural areas the West Midlands Ambulance Service also serves a significant rural area and is successful in meeting performance targets in each of the counties, as well as across the Trust as a whole.

The vision will be achieved by:

- Setting realistic milestones that are understood and communicated to staff and other stakeholders
- Additional investment of almost £7million has been secured from the Strategic Health Authority and Primary Care Trusts to support the delivery of the vision
- Significant increases in the numbers of operational and control room staff
- Aligning existing resources and assets to priorities and taking people off their day job for frontline duty in the short term (Although the Trust may still use agency in the event of a major incident or major public event)
- Working with local authorities to raise awareness and recruitment of Community First Responders

- Improving the effectiveness and capacity of dispatch by providing additional dispatchers and a new post of Emergency Response Co-ordinator to ensure the management of the Control Room
- Ending the Trust's reliance on agency providers for 999 calls by early 2009
- Continuing to work with the voluntary sector during unexpected high demand and in the event of a major incident or major public event
- Aligning the headquarters function to support operational delivery
- Promoting the reputation of GWAS and celebrating its achievements which will in turn boost the morale of staff
- Recognising and rewarding the contribution made by staff who do a great job and deliver excellent patient care
- Being honest and direct with staff about the challenges ahead

Mr Marsh commented that he was confident that GWAS would achieve all national targets by the final quarter of 2008/09.

In response to questions raised by members, the following points were made:

- The importance of being honest with staff, listening to their views, visible leadership across the organisations and making sure they understand the organisation's priorities
- There are no current plans for retained Community First Responders
- The Control Room is being restructured
- The future of the Wiltshire Air Ambulance is secure
- There is a need to improve performance in the Wiltshire sector, which is one of the priorities for the Trust
- There is a need to clarify whether the additional funding has come from PCT contingency funds
- Support from the Committee to reduce patient handovers at hospital is welcomed and that Tamar Thomson is working closely with acute trusts to address this issue
- Although penalties for acute trusts that do not meet patient handover targets may not be the most appropriate solution, incentives for trusts to meet the targets might be more appropriate for PCTs to consider

Mr John Penrose MP joined the meeting at this stage and commented that he fully supported the work of the Joint Committee and its aim to ensure that effective scrutiny takes place. He noted that MPs and ward councillors could raise individual concerns and complaints but that the Joint Committee has an important role in reviewing the effectiveness of the service as a whole.

The Chairman thanked Mr Marsh and Mr Penrose for their comments.

55. Issues Arising from "Managing Our Performance Report", September 2008

There was a discussion regarding issues arising from the 'Managing Our Performance Report' that was submitted to the Great Western Ambulance NHS Trust Board in September 2008.

Vacancies and Recruitment (Page 6)
The 35 vacancies that currently exist within the Trust are a mixture of new posts and staff leaving an existing post.

Patient Transport Service (Page 12)
The figures in the Expenditure Table are expressions of thousands of pounds.

Finance (Page 13)
There was a discussion regarding steps being taken by GWAS to reduce the £616,000 overspend on accident and emergency overtime and agency providers and whether this indicates that the Trust is not operating as efficiently as it could be.

Mr Marsh advised the Committee that some overtime would always be required in order to provide the flexibility that is required when operating an emergency service. It will take 6 to 9 months to recruit and train the new members of staff but this will reduce the Trust's reliance on overtime and agency providers. The Trust will not use agency providers by early 2009. The efficiency of the organisation is best measured by utilisation, management costs and the costs of running the organisation and not overtime payments. The additional investment secured from the SHA and PCTs will be sufficient for the Trust to break even at the end of 2008/09

Concerns were also raised regarding the appropriateness of staff working 12-hour shifts and the risk of fatigue, particularly if staff have a second job or work overtime on rest days.

Mr Marsh noted that a large number of staff choose to work 12 hour shifts. This also reduces the number of shift changes that are required in comparison to 8-hour shifts, resulting in less ambiguity for the Control Room in relation to which crews are on duty. Mr Marsh added that he does consider it to be safe for staff to be working 12-hour shifts and staff and trade unions share this view.

It was resolved:

- **That GWAS will provide monthly figures regarding agency and overtimes expenditure**

Thrombolysis (Page 40)
Mr Marsh reported that thrombolysis will be implemented across the Trust by the end of next year. PCTs determine whether thombolysis is available in acute trusts.

It was confirmed that the majority of agency providers are technicians and not paramedics so not trained to give thrombolytic drugs . Mr Marsh commented that even with additional staff, it would not be possible for a paramedic to attend every 999 call. The priority must be for all life threatening calls to be responded to by a paramedic. When it is identified that a patient may require thrombolysis, the nearest paramedic will be dispatched where possible to administer these drugs.

Referrals to the Clinical Desk (Page 41)
Mr Marsh advised the Committee that the shortage of staff on the Clinical Desk had led to a reduction in the number of referrals from the Control Room. This issue is being addressed as part of the review of the Control Room.

Cardiac Study Days (Page 40)
Mr Marsh confirmed that staff who attend Cardiac Study days do so on a voluntary and unpaid basis. The Trust fully supports staff to further their professional development. The Trust is responsible for funding statutory and mandatory training and this must be a priority. Staff are supported to progress their own additional learning and development but this may not always be funded by the Trust.

Key Performance Indicators (Pages 3 and 5)
It was noted that the summary of A19 Call Connect Performance on Page 3 stated 94.1% compliance with the national target compared with 95.6% on Page 5 of the report.

It was resolved that:

- **GWAS would advise the Committee of the correct figure for A19 Call Connect Performance**

[Note: The correct figure for A19 Call Connect performance in August 2008 was 95.6%]

The Chairman thanked Mr Marsh for his responses.

56. Great Western Ambulance Joint Health Scrutiny Committee Draft Interim Report and Recommendations

The Chairman advised members that the Committee's Draft Interim Report and Recommendations had previously been circulated for comments and that these have been incorporated in the final draft.

He thanked the Members for their involvement and commitment to making the Committee a success, despite the difficulties in actually establishing the Committee. The Committee also thanked Emma Powell and Richard Thorn for their work in supporting the Committee.

Several minor changes were agreed to the final draft.

It was resolved:

- **That Emma Powell will incorporate the changes agreed by the Committee into the Final Version of the Committee's Interim report and Recommendations**
- **That the Committee authorises Emma Powell to circulate the Final Version of the Report according to the distribution list that has previously been agreed by Members [See Appendix 1]**

57. Draft Review of the Operation of the Great Western Ambulance Joint Health Scrutiny Committee February-October 2008

The Draft Review of the Operation of the Great Western Ambulance Joint Health Scrutiny Committee February-October 2008 was agreed.

Councillor While advised Members that the Wiltshire Involvement Network (WIN) has expressed an interest to have a member formally co-opted onto the Joint Committee.

It was resolved:

- **That the Draft Review of the Operation of the Great Western Ambulance Joint Health Scrutiny Committee February-October 2008 be accepted**

58. Dates of Future Meetings

It was resolved that:

- The provisional meeting on 5th December 2008 would be cancelled.
- The future dates of Committee meetings were agreed as follows:
  - 30th January 2009 at 11.00 at Gloucestershire County Council
  - 24th April 2009 at 11.00 at Bristol City Council
  - 31st July 2009 at 11.00 location to be confirmed
  - 30th October at 11.00 Wiltshire County Council

59. Any Other Business

The Committee thanked Mr Marsh for his attendance and open and honest answers to members' questions.

Members also thanked the Chairman for his work in leading the Committee.

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Appendix 1

Distribution List for the Great Western Ambulance Joint Health Scrutiny Committee Draft Interim Report and Recommendations

All individuals that presented evidence to the Committee
Centre for Public Scrutiny
Chair of the Board of all Primary Care Trusts in the GWA region
Chair of the Board, Great Western Ambulance NHS Trust
Chairs of all Health Overview & Scrutiny Committees in the GWA region
Chairs of Overview & Scrutiny in all Local Authorities within the GWA region (Including District Councils)
Chief Executive Great Western Ambulance NHS Trust
Chief Executive of all Primary Care Trusts in the GWA region
Chief Executive of the Local Government Association
Chief Executive of the Strategic Health Authority
Chief Executives of all Local Authorities within the GWA region (Including District Councils)
IdEA
Leaders of all Local Authorities within the GWA region (Including District Councils)
Local Involvement Networks in the GWA region
Local media
MPs within the GWA region
Secretary of State for Health
South West Councils (formally South West Local Government Association)

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Appendix 2

Update regarding the recommendations of the Avon, Gloucestershire, Wiltshire and North Somerset Cardiac Network in relation to the roll out of primary angioplasty across the region (Minute 51)

Primary angioplasty involves the insertion of a small balloon catheter into a coronary artery in order to clear a blockage. This is an initial treatment; the alternative would be to use clot-busting thrombolytic drugs. The National Infarct Angioplasty Project (NIAP) was commissioned by the DH to undertake a feasibility study of developing primary angioplasty services in the UK. The final report will be published in the next few months. However, an initial report was published in February 2008 and the key findings were:

- The development of primary angioplasty services is feasible in a variety of geographical settings
- Establishing a primary angioplasty service requires a multidisciplinary approach and good communication between all stakeholders
- Acceptable call-to-balloon times are achievable by direct or indirect admission to the primary angioplasty centre but the ideal is undoubtedly direct admission to the catheter laboratory at the primary angioplasty centre

The provision of primary angioplasty services is growing rapidly. According to the latest Myocardial Ischemia National Audit Project (MINAP) report published in June 2008, the use of primary angioplasty continues to increase rapidly as more hospitals are able to provide this procedure. The provision of primary angioplasty services remains limited outside of major teaching hospitals and metropolitan centres. However, the scope of these services in district general hospitals is growing very rapidly. A 9-5 Mon-Fri primary angioplasty services have been established at Frenchay Hospital and a 24/7 service is running at the Bristol Royal Infirmary for Avon patients. Taunton and Somerset NHS Foundation Trust and the Royal United Hospital in Bath have also established a 9-5 Mon-Fri service. There are also plans to establish similar services at Cheltenham General Hospital. The *Draft Strategic Framework for Improving Care in the South West 08/09 to 10/11* published by the NHS South West has stated that 95% of eligible patients with myocardial infarction need to be treated by primary angioplasty within 3 hours of onset by March 2011.

Great Western Ambulance Service NHS

NHS Trust

Pre-hospital thrombolysis (PHT) and Primary angioplasty (PPCI)

Introduction

Acute myocardial infarction (AMI) is a common medical emergency. Classically, it is caused by a blood clot on top of ruptured atheromatous plaque which occludes a coronary artery. This blockage, if sustained for more than 20 - 30 mins, will cause death of the myocardium (heart muscle) in the territory supplied by the affected artery. The longer this occlusion is allowed to last, the larger the area of dead muscle. This may be sufficient to cause an electrical disturbance and result in cardiac arrest and death. In any event, the damaged heart muscle may well be sufficient to cause symptomatic heart failure following recovery from the acute episode.

When this full-blown syndrome of coronary artery occlusion and myocardial muscle death occurs it will usually result in changes detectable on the electrocardiogram (ECG) as 'ST segment elevation. This is why the syndrome is known as an ST segment elevation myocardial infarction (STEMI).

Treatment of STEMI

There are two widely recognised and well evidenced types of treatment available:

- Thrombolysis – the injection of a drug which breaks down the blood clot in the coronary artery. It may be delivered in hospital or out of hospital (PHT) The PHT criteria being slightly narrower than in-hospital thrombolysis.

- Angioplasty (also known as Percutaneous Coronary Intervention – PPCI) when a catheter is inserted into an artery in the groin or arm and passed under X ray control to the affected coronary artery and a balloon inflated to break down the blood clot. Following this it is usual for the coronary artery to be 'splinted' open by a mesh stent.
  Angioplasty may be 'Primary' when this is used as the first line treatment for a STEMI or 'Rescue' when it is used following failure of a thrombolytic drug to break down the blood clot effectively (occurs in approximately 6.5% of cases). It requires access to a specialist catheter laboratory and a team including cardiac technicians and a specially trained 'Interventional' cardiologist to perform These must be available at very short notice.

Which treatment is best?

There is a widespread belief that angioplasty is superior to thrombolysis in *all* circumstances. The evidence however, is not so clear cut. The factors that determine the best treatment for a particular individual include:

- How long has the pain been present?
- Is the individual within the inclusion criteria for thrombolysis?
- Is the thrombolytic available in the pre-hospital setting?
- How long will it take to get to an available catheter lab?

The current guidelines within the Avon, Gloucestershire and Wiltshire (AGW)[1] cardiac network are:

- Pain > 2 hours = Primary angioplasty (if available) and can be accessed within 45 mins of diagnosis – otherwise give PHT.
- Pain < 2 hours = Primary angioplasty (if available) and can be accessed within 15 mins of diagnosis – otherwise give PHT
- In all cases when PHT is not available for whatever reason Primary angioplasty is preferable to in-hospital thrombolysis
- In certain clinical situations Primary angioplasty is always the best treatment e.g. Cardiogenic shock.

The implementation of these guidelines is limited by the availability of suitable catheter laboratories and teams.

Services in the GWAS area

The network is working with local PCT commissioners to determine the configuration of services locally. Bristol Royal Infirmary is currently the only trust offering a 24/7 primary angioplasty service. Many other local trusts offer a partial service (i.e. when a lab and team is available between elective procedures) and some aspire to offering a full or partial service in the future.

Guidance to ambulance clinicians

Current guidance reflects the local availability of PPCI and the recent widening of the catchment area for PPCI at the BRI. Most paramedics can deliver 'decision supported' PHT i.e. after transmission of ECG to the receiving unit. Some are able to deliver 'autonomous' thrombolysis without the need to obtain a second opinion on the ECG – this obviously speeds the process to delivering PHT.
Increasingly, when PPCI is indicated, ambulance clinicians are liaising directly with the hospital and delivering the patient directly to the catheter lab.

Dr S Rawstorne
Clinical Director GWAS
15/01/09

[1] Recently the AGW network has incorporated Somerset to become SWAG network! Salisbury is part of the Wessex network.