Monitoring the Rural Ambulance Services

The Patient and Public Perspective

The approach to Forest in Teesdale School

Acknowledgement to Accident and Emergency Ambulance Crews

The Patient and Public Involvement Forum would like to pay tribute to the dedicated service which the Paramedics and Technicians provide in our area. Comments and recommendations contained in this report relate to shortcomings within the system, not to the work undertaken by this vital part of our National Health Service.

Report by members of the County Durham Primary Care Trust PPI Forum
Jean Heatherington, Margaret Dent and
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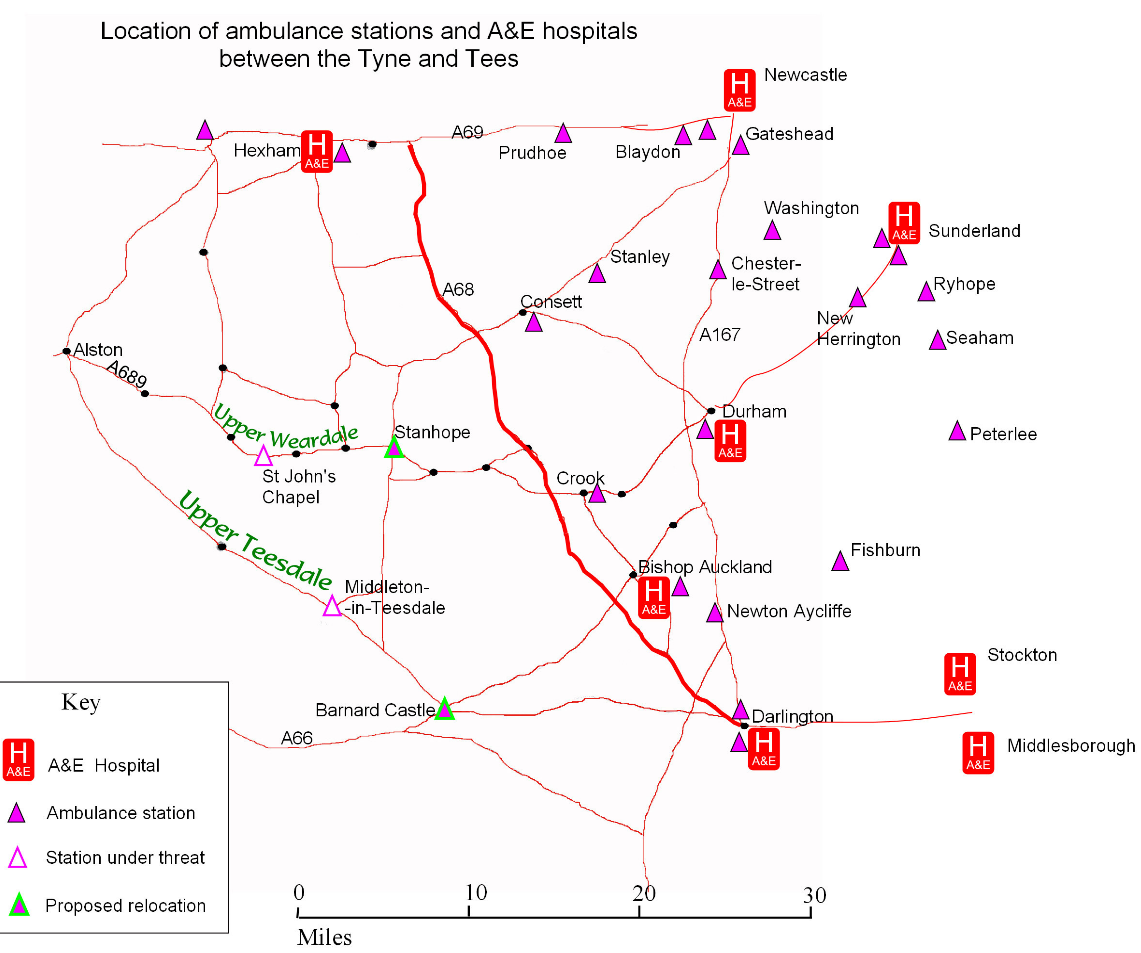
February 2008

Weardale and Teesdale in relation to A&E hospitals and ambulance stations



Summary

1. Monitoring was set up to address concerns expressed by residents in postcodes DL13 1 (upper Weardale) and DL12 0 (upper Teesdale).

2. The PCT failed to provide leadership in the monitoring process.

3. NEAS presented no data which monitored the effect of the service on the above postcodes but has instead, in their draft final Q4 report, based its conclusions and recommendations on data averaged across the whole area masking wide variations in response times. Response time improvements were to be expected, in any case, with the change from stand by to fully manned 24/7 service.

4. Raw data collected by the ambulance crews and collated by the CDPCT-PPI highlights key concerns in both upper Teesdale and Weardale related to ‘out of area’ activities, both when the local ambulance is drawn out of area and when ‘out of area’ ambulances are called in when the local ambulance is not there (or on a meal break). Raw data demonstrate that from the base at Stanhope the ambulance is 3 times more likely to be drawn out of the area than from St John’s Chapel. In Teesdale an out of area ambulance is attending to calls in upper Teesdale for up to 45 % of the time.

5. The target driven proposals take little account of the distribution of population or the topography of these huge catchment areas.

6. The PPI welcome the developing Community based Paramedic Service in Weardale but are disappointed that team working across health care professionals has not been achieved in Teesdale

7. As there has been no attempt to differentiate data for the upper Dales and no evidence has been presented to justify the relocation of the ambulance bases, any decision to close the stations would not only be most inappropriate, but totally unacceptable to the residents of the upper Dales, therefore the PPI does not accept, as it stands, the NEAS report, its conclusions or recommendations to close St John’s Chapel or Middleton in Teesdale stations.
8. At the last monitoring meeting the PCT backed down from its promise to hold public meetings saying that there was no statutory requirement to do so. The PPI have therefore taken the initiative to organise public meetings because they feel that there is both a duty and moral requirement to answer their original concerns by feeding back to the public the findings from the monitoring process.
9. The Bellingham Incident in Northumberland (Appendix VIIa,b,c,) highlighted a failure by the Health Services to get a very sick patient to hospital in less than 8 hours, despite all parties claiming that they had met their target. What good are targets? Where is rural equity? We take this incident as a terrible warning of how things might be if the ambulance service implements its proposal of closing stations at St

John's Chapel and Middleton inTeesdale. Where was the Bellingham Community Paramedic in this scenario and how did it help the patient that every health professional hit their target? This incident also highlights concerns about the effectiveness of the Out of Hours Service and Emergency Care Assistants. (Appendix VII)

Recommendations

1. The St John's Chapel and Middleton in Teesdale ambulance stations remain open and in use. The PCT must demonstrate that it is taking rural equity seriously and make a commitment to residents of the upper dales that as part of its "Big Conversation" not only is it listening but also implementing services which residents consider to be essential.

2. When the Weardale or Teesdale ambulance leaves its area a rapid response vehicle or another A&E vehicle should provide cover by moving **into the area.** This vehicle would need to be positioned to ensure a reasonable response time to the furthest extent of the Upper Dales.

1. Introduction and Background

Following concerns raised during public consultation events to discuss the document "Modernising rural ambulance services" in the summer of 2006, Durham Dales Primary Care Trust (PCT) (as it was then) agreed to delay a decision on the relocation of Middleton-in-Teesdale and St John's Chapel ambulance stations until a twelve month monitoring process had been undertaken.

To address public concerns that any relocation would result in a "significant change in service that may have a detrimental effect on the most rural and isolated areas" (Durham Dales PCT Board Report, September, 2006), it was agreed that current ambulance stations would remain in place until changes had been "evaluated and proved to be more effective" (ibid).

Over the past twelve months, the North East Ambulance Service (NEAS) has produced and presented quarterly monitoring reports of emergency vehicle activity levels, including, at the request of the Public and Patient Involvement Forum (PPI), raw data compiled by the paramedics that shows both the vehicle starting point and the incident location.(Appendix I) In addition, the PPI members of the group receiving the monitoring reports have visited NEAS headquarters to view the new NHS Pathways System and have continued to seek stakeholder views via their local networks and contacts.

2. Role of the PCT in the monitoring process

The CDPCT, as the commissioning body, has failed to

1. manage the monitoring process
2. set clear, agreed monitoring criteria
3. provide continuity and consistency of personnel attending monitoring meetings (four quarterly monitoring meetings have had three different chairmen).
4. **ensure that the data provided to the monitoring team differentiated A&E activity in postcodes DL12 0 and DL13 1 in order that the effect of station closure on Upper Teesdale and Upper Weardale could be properly evaluated.**
5. challenge or evaluate any part of the NEAS report
6. address several areas of concern highlighted by Overview and Scrutiny Health Sub Committee report of 5th September 2006
7. engage all relevant parties in the monitoring process - GPs, paramedics, First Responders, Richardson Hospital etc.
8. require NEAS to provide relevant raw data repeatedly requested by CDPCT PPI Forum members of the group
9. engage paramedics in the importance of the data they were asked to collect
10. be informed by, or responsive to, the opinions of local people re Government Health White Paper Chapter 7 'Our Health, Our Care, Our Say'

3. The NEAS Report

NEAS presented no data which monitored the effect of the service on the above post codes but instead based its conclusions and recommendations on data averaged across the whole area masking wide variations in response times.

4. Concerns raised by Raw Data

Information presented during the monitoring process has done nothing to alleviate or answer key concerns which relate specifically to the more remote areas of Weardale and Teesdale.

4.1 Weardale

The key concern is that if the station at St John's Chapel is closed and the base moved to Stanhope the Weardale ambulance will be drawn more often to support the service in mid and east Durham, as the raw monitoring data demonstrates. This is to the detriment of the population in the whole of the dale.

4.2 Teesdale

the key concern is that this has already happened in practice because the station at Middleton has not been used since December 2006. Insufficient evidence has been presented to show where an ambulance is travelling from, or the time taken, to answer calls in the upper dale as the statistics are not differentiated. Evidence of an overall improvement masks a worsening picture in some areas. Teesdale covers an area of 836 sq km and has a population of 24,000 ranging from widely dispersed settlements to market towns.

Weardale

Raw data showed that the further east the starting location of the ambulance at call-out the more often it was called out of the area.(Appendix IIa)

- 57% of job locations starting from Wolsingham were east of Harperley Banks on the A68
- 30% of job locations starting from Stanhope were east of Harperley Banks on the A68
- 11% of job locations starting from St. John's Chapel were east of Harperley Banks on the A68

It also showed that in total 38% of jobs carried out by the Weardale ambulance were to the east of Harperley Banks. (Appendix IIb)

This raises the concern that an ambulance based permanently in Stanhope would be used **out of area** more often as has happened in Teesdale where the base has been relocated to Barnard Castle.(Appendix III and IVa)

There is also evidence that when the ambulance is out of the area Weardale can be left with very poor cover. The following incident serves to illustrate how the local ambulance can be redeployed once out of the area.

On 18th December an elderly lady became ill at a concert in Ireshopeburn and was unconscious when the ambulance was called. The Weardale ambulance had already been called out of the area and was then called to attend an incident at Seaham! The nearest available ambulance was just to the west of Darlington and took 45 minutes to arrive.

Data shows that 25% of call outs for the Weardale ambulance are made when the ambulance is already out of the area.

It is recognised that the service will operate widely in the community but there are pragmatic reasons why the base at St John's Chapel should be retained.

- it provides existing designated facilities for ambulance crews
- appropriate garaging and parking facilities with sufficient protection for bad weather such as frost and snow
- cleaning and maintenance facilities including available and easily accessible equipment charging points
- a suitable entrance with good lines of sight
- no further capital investment is required as would be the case if it moved to Stanhope

Regular attendance at the St John's Chapel base also ensures a visible and reassuring daily presence of the ambulance in the upper Dale.

It is questionable whether all of the facilities, presently at St John's Chapel, can be provided at Stanhope. This was acknowledged by the Director of

Ambulance Operations, Mr Paul Liversidge, in a letter to Helen Suddes of the Durham County Primary Care Trust, dated 19.06.07 *"Stanhope Community Hospital is a temporary base and* ***does not have sufficient facilities*** *for the crews to operate there full time, logistically we have agreed for them to pick up their vehicle at the start of their shift at St John's Chapel, move down to Stanhope and return for their meal breaks and to finish their shift.* ***This arrangement exists due to the reduced facilities at Stanhope Hospital.****"*

If the Station at St John's Chapel closed there is a concern that not all of the functions presently conducted by the ambulance crews could be carried out at Stanhope, causing the ambulance to travel further a field for facilities.

Teesdale

The situation in Teesdale is of even greater concern because the Teesdale ambulance spends much less time in the Middleton area than the Weardale ambulance spends at St John's Chapel. Raw data for Teesdale, spanning the second and third monitoring quarters, was unavailable to the group. NEAS and the PCT failed to ensure this data was provided. However, the data presented in the first quarter recorded no calls west of Barnard Castle attended by the Teesdale ambulance and only ten in the rest of the area. All other calls recorded in the three month period were to patients out of Teesdale (Appendix III). Ten incidents west of Barnard Castle were recorded as attended by the Teesdale crew. Does this mean, therefore, that all other calls in Teesdale were attended by ambulances from out of the area such as Darlington, Newton Aycliffe etc.? The monitoring process has failed to allay public concern about A&E ambulance cover in Upper Weardale and Upper Teesdale.

Historically Teesdale has had two stations, Middleton and Barnard Castle but a combined rota was worked and the crew was based at Middleton for **one third of the time**. The ambulance is now based full-time in Barnard Castle and the Middleton station has been 'mothballed' throughout the monitoring period, this has led to a public belief that the decision to close the station had already been taken and implemented in December 2006, notwithstanding that the station has been repainted inside and out in January 2008.

The monitoring process was charged with proving that **the "significant change in service would not have a detrimental effect on the most rural and isolated areas"** however, the ambulance spends far less time west of Barnard Castle than it used to and NEAS figures (not derived from raw data) demonstrates that ambulances from other stations such as Newton Aycliffe, Bishop Auckland and Weardale are attending upper Teesdale residents up to 45% of the time, rather than the Teesdale ambulance (Appendix IVa). This inevitably means considerably longer waiting periods, **well outside the target times**, and happens when the Teesdale crew is called out of the area to attend incidents in Darlington and Bishop Auckland or when transporting a patient to hospital etc. In these circumstances the local vehicle may be out of the Dale for up to four hours. Weardale and Teesdale ambulances are

sometimes used to transfer patients between hospitals e.g. from Darlington Memorial Hospital to the R.V.I., Newcastle.

The statistics produced for the monitoring group do not differentiate between the upper and lower Dales and raw data from the Teesdale paramedic team shows virtually no presence west of Barnard Castle.

Equally, the monitoring information does not answer crucial “what if” questions in relation to emergencies that occur in very remote areas west of Stanhope and Middleton such Killhope, Cauldron Snout, High Force etc. The Teesdale ambulance also has to cover a long stretch of the A66, with notorious accident black spots including the exposed Pennine section beyond Bowes to Stainmore and the Cumbria border. While recognising the need to comply with national performance targets, Taking Health Care to the Patient: Improving NHS ambulance Services (2004) clearly states that **“It is a performance requirement that patients receive the same level of service wherever they live”. Equally, an insistence on rural equity has been a central theme of much government policy over the past several years. Payment by targets however, is at odds with delivering rural equity.**

In Teesdale the concerns about the closure of the Middleton base revolve around the long distances and travel time from the facilities in Barnard Castle, Darlington and Bishop Auckland for residents and visitors to the Upper Dale. (Appendix Va). The ‘golden hour’ (the critical time span for treatment to be administered to give the best possible outcomes for patients with life threatening conditions) seems a hollow sham if it takes almost that long for an ambulance to arrive, let alone transport the patient to hospital. A & E crews are trained to stabilise patients but cannot be expected to do the same job as a full A&E team of doctors and nurses using more sophisticated equipment in controlled hospital conditions. It is the luck of the draw if an ambulance is available and waiting at Barnard Castle, the chances are high that it will arrive from further away. This concern is mirrored by residents of upper Weardale. (Appendix V)

5. The Rural Situation

Upper Teesdale and Weardale have sizeable though scattered populations and this runs contrary to the perception that they are sparsely populated.

Upper Weardale. There are 12 occupied farms visible on this photograph as well as the village of Lanehead. Other houses in the valley bottom are not visible. This is not a depopulated landscape. Lanehead is 11 miles from Stanhope and 31 miles from Bp. Auckland hospital.

Statistics presented in the consultation are misleading – a press release in February 2006 reported that Stanhope had a population of 2000 and St John's Chapel 300 whereas figures from the electoral roll show that the population of Stanhope is 1,526 while there are 9 villages and 15 hamlets to the west of Stanhope whose population totals 1,848 (electoral role figures). These need to be taken into account along with two substantial new developments at St John's Chapel and Eastgate.

Similarly, Middleton was represented as having 1500 residents; however a population of more than 4,100 live in 17 villages and hamlets as well as several hundred dispersed farmsteads and dwellings to the north-west of Barnard Castle. Excluding the A66 / Bowes corridor, this figure accounts for more than 17% of Teesdale's population, almost as many as in Barnard Castle itself, yet occupying approximately 50% of the total area of Teesdale. (DCC website based on updated census figures).

Additionally both upper Dales are part of an Area of Outstanding Natural Beauty (AONB) covering 1983 sq km, with a dispersed population of 12,000 (source AONB) attracting thousands of extra visitors every year increasing the incidence of road traffic accidents, outdoor injuries and general health emergencies. If both St John's Chapel and Middleton ambulance stations close there will be no ambulance based in the whole of this AONB.

The proposals presented by NEAS appear to be totally target driven and take little account of rural equity. A performance driven service based on target setting and dynamic deployment will always provide a second-class service to isolated areas because it does not take account of the extended journey time when factors such as rural topography and isolated hamlets are included. The Emergency Medical Journal's observation that the **"percentage chances of seriously ill patients surviving ambulance journeys decreases according to distance travelled"** is particularly crucial when the time spent waiting for an ambulance to arrive is added. Emergency vehicles in this part of the county often have to negotiate a narrow, winding spine road, farm tracks with gates, outlying dwellings, lack of street lighting and remote dwellings that are often not known by anything other than local names and this needs to be factored in. A further drawback of 'out of area' vehicles attending is the risk of time delay due to lack of local area knowledge. Concerns about this were expressed at public consultation meetings and NEAS promised that it would be addressed. No evidence has been presented. This is the justification for an ambulance base in both St John's Chapel and Middleton in Teesdale.

6. The Community based Paramedic Service

We fully support the work of the paramedics working in the community and hope that this will continue to be developed to enhance the health care within the upper Dales.

1. Expectations of better team working across health care professionals do not seem to have been achieved. For example, GPs appear to lack

information relating to systems and processes. In a recent letter from a GP Practice in Middleton-in-Teesdale, the following issues were raised:

   a. The ambulance is not always available when needed and we seem to get more “out of area” ambulances attending
   b. What provision is there for cover when the Middleton-in-Teesdale ambulance is dealing with a call from another area
   c. The Blackberry is not robust when out of signal range, what back-up is there
   d. The ambulance has disappeared from the Middleton-in-Teesdale station altogether
   e. The new telephone number for telephone ambulance requests had not been disseminated to GP Practices
   f. The Practice could not book a Saturday morning ambulance for a patient needing to go to James Cook University Hospital as a stretcher case. The Practice was advised that the patient could ring on the Saturday morning to see if an ambulance was available but the telephone was not answered. The patient had to use a private ambulance

2. There is the potential for confusion and/or conflict in relation to roles and demands, for example in relation to the work of paramedics, GPs, community nurses and first responders.
3. Is the promised training of paramedics and technicians in their Community role continuing?
4. How are GPs, hospitals, Out of Hours Services, Community nurses, etc. communicating with each other and working as a team and is communication between NEAS and the PCT adequate? For example, is NEAS providing sufficient information on systems and processes? Stanhope Community hospital is liaising with the Weardale ambulance crew but there has been no feedback on the situation at the Richardson Hospital, Barnard Castle.

7. Other Concerns

The reconfiguration of the PCT has resulted in a less than rigorous approach to the monitoring process with NEAS being left to “self assess”. The PCT, as the commissioning body, has failed in its duty to take an active lead role in respect of scrutiny.

Quality of A & E Service to rural communities in Upper Weardale and Upper Teesdale

1. There is a systemic bias towards more densely populated areas and a lack of coverage in remote areas that have a similar number of residents but more dispersed communities resulting in a focus on demand rather than need.
2. The first responder system, although a valuable service, relies entirely on volunteer support and as such lacks absolute stability and sustainability. There is only one First Responder in Upper Teesdale. There are also questions surrounding the level of equipment they carry and their inability to administer drugs; this is particularly important

given that the clock for a targeted response time stops when the first responder arrives, (if this is earlier), rather than when the A&E paramedic, technician and ambulance arrive. Though this is correct procedure it is misleading and influences target times.

3. How secure is funding for paramedic and technician crews, is there a possibility that we may lose technician level support and revert to the Emergency Care Assistant option favoured by NEAS in the consultation?
4. There is no information relating to the use of the air ambulance, a resource funded solely by charitable donation. Has this usage increased because of the closure of the Middleton station?
5. The impact of meal break cover has not been taken into account. Crews on meal break are not called out even if they are the closest to the incident. The impact of this policy is likely to be far greater in the upper Dales as there are no other ambulances nearby to call on. (Appendix VI)

8. Public Voice

A Public meeting was held at St John's Chapel on 19th Feb and one is planned for Middleton inTeesdale on 3rd March. Councillor Shuttleworth chaired the Weardale meeting and Councillor Bell will chair the Teesdale one. The CDPCT PPI members gave a power point presentation to report back on the monitoring process.

Outcomes from SJC Meeting

- Over 200 attended the meeting.
- People were shocked and upset at the implications of ambulance relocation.
- 56 statement and comment sheets were filled out at the meeting.
- many other attendees expressed an intention to write to the CDPCT and MP to express their concern.

Conclusion

The NEAS case for relocation is based on improved response times across the region. These response times would have improved in any case because of the ending of standby, the introduction of 24/7 working and fully manned stations. The improvements shown over all hide concerns about levels of service in Upper Weardale and Upper Teesdale. These concerns have always been about response times to outlying areas and the monitoring process has failed to address this because all the information is averaged across all the post codes in each area.

When the ambulances are used out of area the Dales are left vulnerable. While the Community Paramedics in the Dales are part of an overall service across the NE of England their situation is isolated and catchments are huge. It has been shown that external vehicles responding to incidents within the Dales can take up to an hour to arrive on scene. There should be a

predisposition against using the Dales ambulances out of area and towards returning them to base as soon as possible.

Insofar as the monitoring was set up to examine the effect of the service on the concerned residents of the upper dales the only relevant evidence, so far presented, to the monitoring group has been by CDPCT PPI Forum who have extracted and analysed information from raw data collected by the paramedics. This raw data does not include response times, as none were provided, although they were part of the information included in the pro forma designed by the PPI (Appendix I). However, it has illuminated the activity of ambulance movements, in particular it has shown that the Teesdale ambulance operates for much of its time around Bishop Auckland and Darlington and that the Weardale ambulance, when based in Stanhope, is much more likely to be drawn into east Durham. This worrying trend to use the ambulances out of area is supported by NEAS figures (Appendix IV)about 'out of area' activity and relates directly to the concerns of residents and GPs in the upper Dales that they are often waiting 40 minutes to an hour and a half for an ambulance to arrive.

The incident at Bellingham on Feb 2nd 2008 provides a sober reminder of the vulnerability of 'real' patients in outlying rural areas.

The CDPCT seems prepared to accept NEAS's subjective self asssessment and has placed little or no value on the relevant and substantiated evidence presented by the CDPCT PPI Forum.

As there has been no attempt by NEAS, during a whole year of monitoring, to differentiate data for the upper Dales there is no justification for the relocation of the ambulance bases and any decision to close the stations would not only be most inappropriate, but totally unacceptable to the residents of the upper Dales.

Recommendations

1. The St John's Chapel and Middleton in Teesdale ambulance stations remain open and in use. The PCT must demonstrate that it is taking rural equity seriously and make a commitment to residents of the upper dales that as part of its "Big Conversation" not only is it listening but also implementing services which residents consider to be essential.

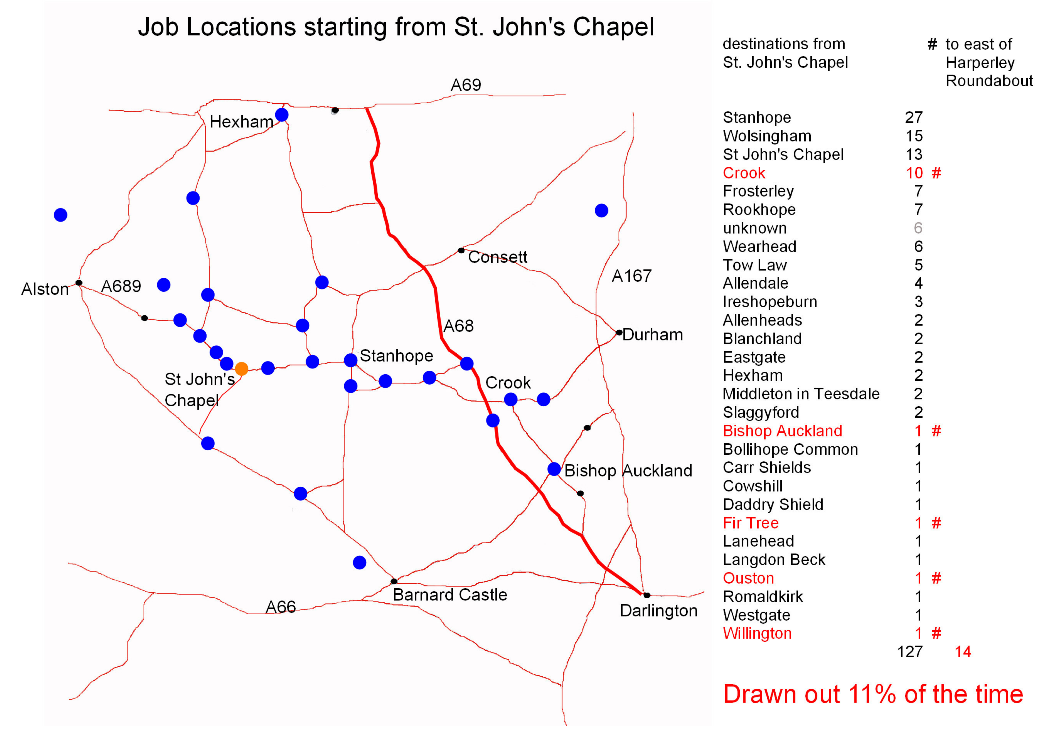
2. When the Weardale or Teesdale ambulance leaves its area a rapid response vehicle or another A&E vehicle should provide cover by moving **into the area.** This vehicle would need to be positioned to ensure a reasonable response time to the furthest extent of the Upper Dales.

Appendices

Appendix I Pro forma suggested by CDPCT PPI Forum to collect raw data

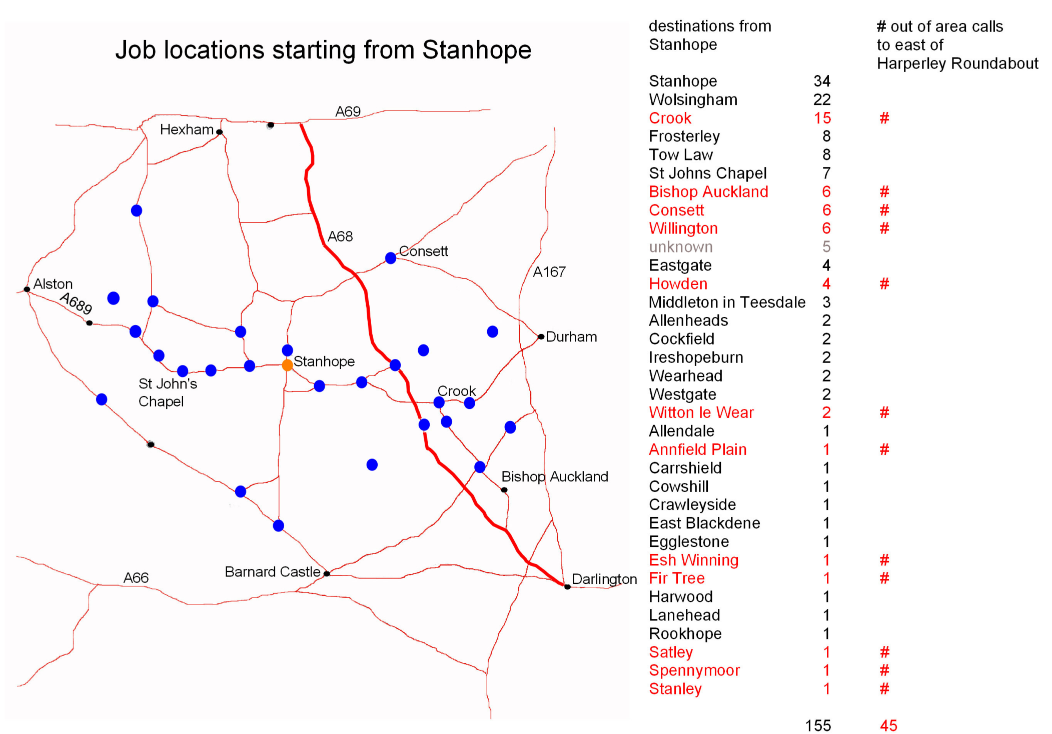
Date and time of call out 23/11/06	Starting location	Call ID Inci-dent No	Cat/ S/by	Time taken to arrive	Incident Location	Distance driven	Outcome – transport, hospital, treat and leave, other	Comment
08.00	Middleton		A	7 mins.	Thringarth	3.2 m	A&E DMH	

Maps of Weardale Appendix IIa



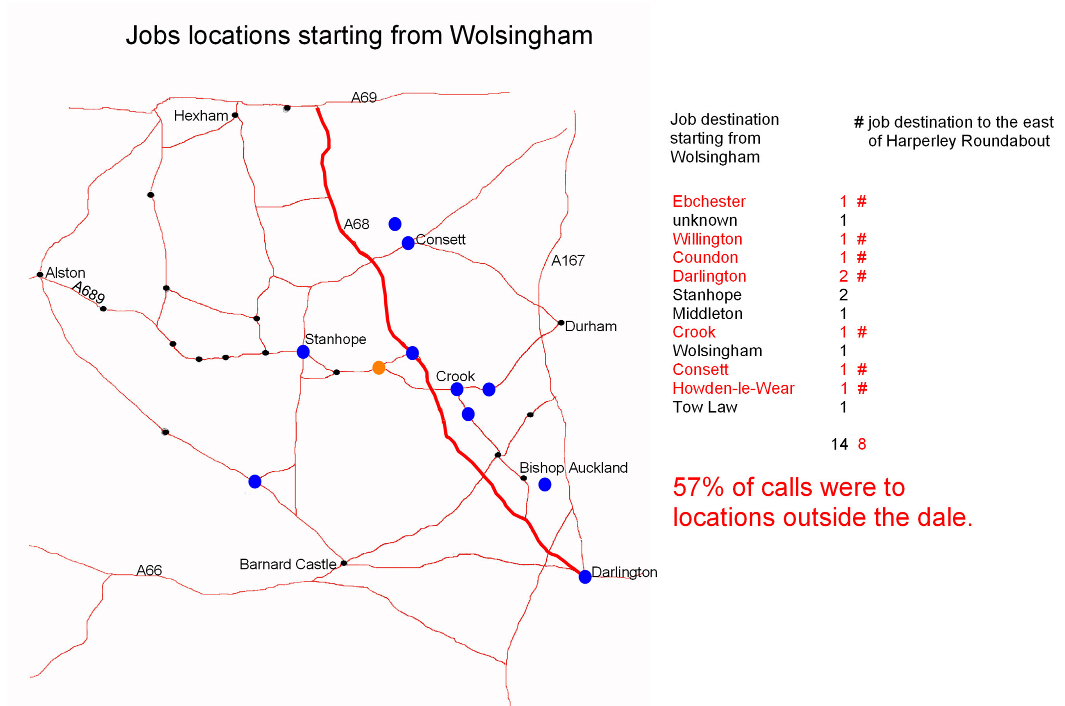
destinations from St. John's Chapel		# to east of Harperley Roundabout
Stanhope	27	
Wolsingham	15	
St John's Chapel	13	
Crook	10	#
Frosterley	7	
Rookhope	7	
unknown	6	
Wearhead	6	
Tow Law	5	
Allendale	4	
Ireshopeburn	3	
Allenheads	2	
Blanchland	2	
Eastgate	2	
Hexham	2	
Middleton in Teesdale	2	
Slaggyford	2	
Bishop Auckland	1	#
Bollihope Common	1	
Carr Shields	1	
Cowshill	1	
Daddry Shield	1	
Fir Tree	1	#
Lanehead	1	
Langdon Beck	1	
Ouston	1	#
Romaldkirk	1	
Westgate	1	
Willington	1	#
	127	14

Drawn out 11% of the time



destinations from Stanhope		# out of area calls to east of Harperley Roundabout
Stanhope	34	
Wolsingham	22	
Crook	15	#
Frosterley	8	
Tow Law	8	
St Johns Chapel	7	
Bishop Auckland	6	#
Consett	6	#
Willington	6	#
unknown	5	
Eastgate	4	
Howden	4	#
Middleton in Teesdale	3	
Allenheads	2	
Cockfield	2	
Ireshopeburn	2	
Wearhead	2	
Westgate	2	
Witton le Wear	2	#
Allendale	1	
Annfield Plain	1	#
Carrshield	1	
Cowshill	1	
Crawleyside	1	
East Blackdene	1	
Egglestone	1	
Esh Winning	1	#
Fir Tree	1	#
Harwood	1	
Lanehead	1	
Rookhope	1	
Satley	1	#
Spennymoor	1	#
Stanley	1	#
	155	45

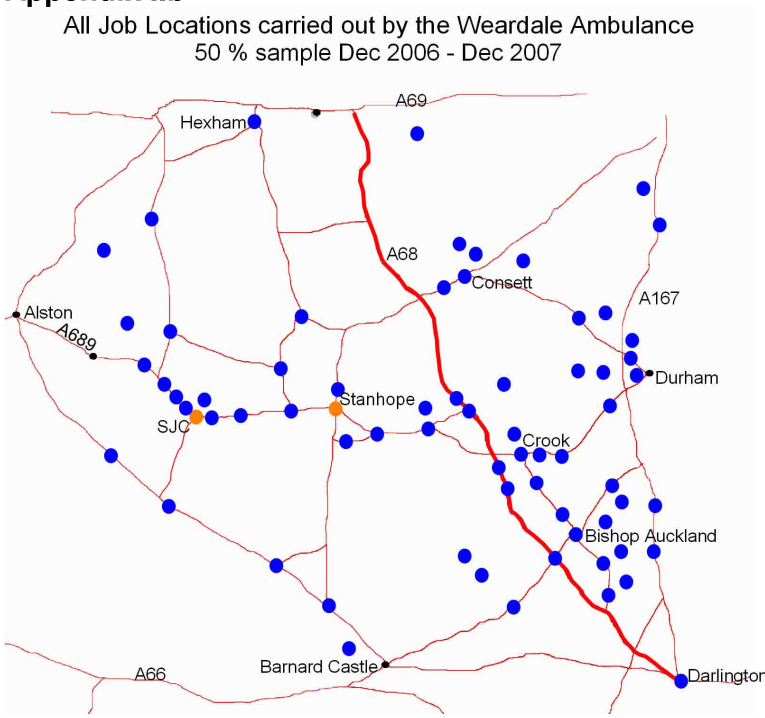
Ambulance drawn out 30% of the time



Job destination starting from Wolsingham		# job destination to the east of Harperley Roundabout
Ebchester	1	#
unknown	1	
Willington	1	#
Coundon	1	#
Darlington	2	#
Stanhope	2	
Middleton	1	
Crook	1	#
Wolsingham	1	
Consett	1	#
Howden-le-Wear	1	#
Tow Law	1	
	14	8

57% of calls were to locations outside the dale.

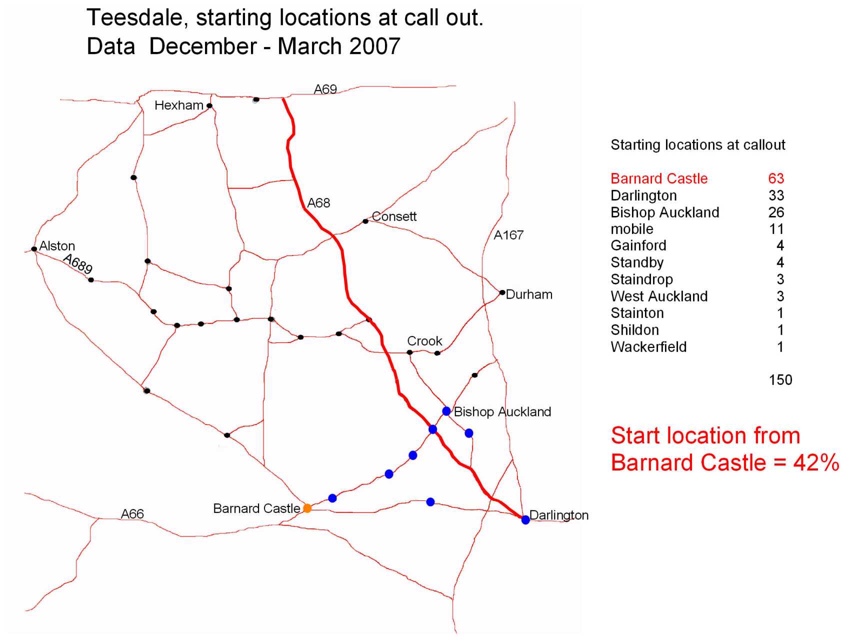
Appendix IIb



This map highlights the amount of 'out of area' activity carried out by the Weardale ambulance. 163 / 426 jobs carried out by the Weardale ambulance were to the east of Harperley Banks, (38%)

Appendix III

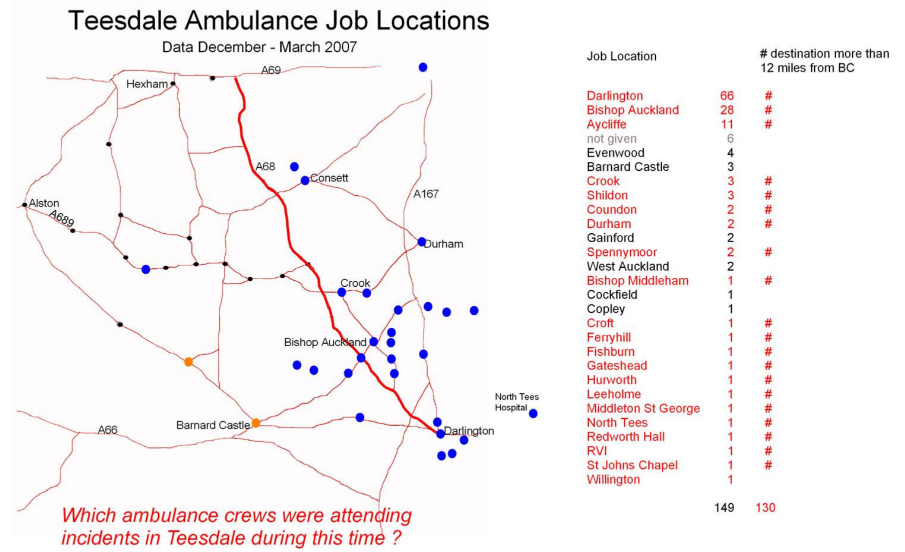
From raw data December 2006-March 2007



Starting locations at callout

Barnard Castle	63
Darlington	33
Bishop Auckland	26
mobile	11
Gainford	4
Standby	4
Staindrop	3
West Auckland	3
Stainton	1
Shildon	1
Wackerfield	1
	150

Start location from Barnard Castle = 42%

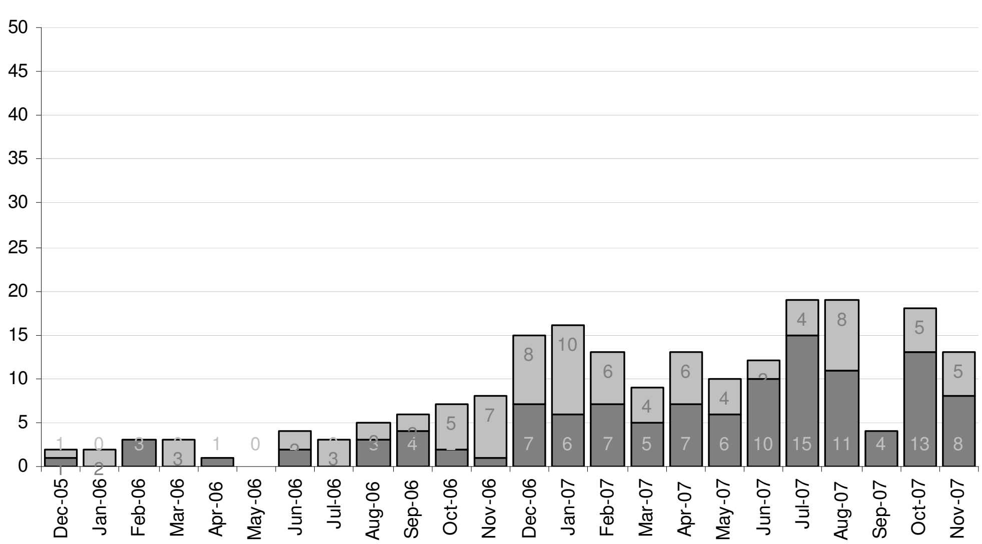


Job Location		# destination more than 12 miles from BC
Darlington	66	#
Bishop Auckland	28	#
Aycliffe	11	#
not given	6	
Evenwood	4	
Barnard Castle	3	
Crook	3	#
Shildon	3	#
Coundon	2	#
Durham	2	#
Gainford	2	
Spennymoor	2	#
West Auckland	2	
Bishop Middleham	1	#
Cockfield	1	
Copley	1	
Croft	1	#
Ferryhill	1	#
Fishburn	1	#
Gateshead	1	#
Hurworth	1	#
Leeholme	1	#
Middleton St George	1	#
North Tees	1	#
Redworth Hall	1	#
RVI	1	#
St Johns Chapel	1	#
Willington	1	
	149	130

Which ambulance crews were attending incidents in Teesdale during this time ?

Appendix IV

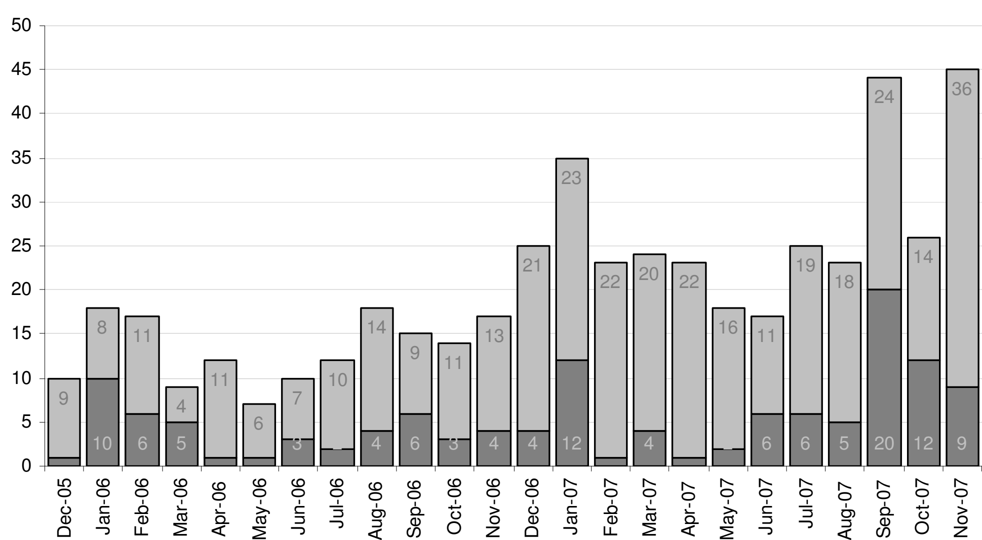
Category A Responses in Weardale by the Weardale Vehicle



Appendix IVa

Category A Responses in Teesdale by the Teesdale Vehicle

Out In Teesdale



Appendix V
Distances to emergency facilities from Locations in Weardale

Location	Post code in Weardale	Distance/ Time from Stanhope Community Hospital DL13 2JR	Distance from A&E and Out of Hours Centre, Bishop Auckland DL14 6AD	Distance from University Hospital of North Durham DH1 4SQ
Wearhead School	DL13 1BN	9.0 miles/ 17 min.	29.8 miles/ 53 min.	30.7 miles/ 1 hr 1 min.
Lanehead	DL13 1AJ	10.7 miles/ 21 min.	31.5 miles/ 57 min.	32.5 miles/ 1 hr 4 min.
Killhope Wheel	DL13 1AR	11.9 miles/ 23 min.	32.7 miles/ 59 min.	33.7 miles/ 1 hr 6 min.

Appendix Va
Distances to emergency facilities from Locations in Teesdale

Location	Post code in Teesdale	Distance/ Time from Barnard Castle Ambulance station DL12 8ET	Distance from A&E and Out of Hours Centre, Bishop Auckland DL14 6AD	Distance from Memorial Hospital, Darlington DL3 6HX
Forest School	DL12 0HA	16 miles/ 42 mins	33 miles / 1 hr 2 min.	36.5 miles/ 1 hr 12 min.
Birkdale	DL12 0JA	22 miles/ 1 hr 6 min.	37 miles/ 1 hr 26min.	41 miles/ 1 hr 36 min.
Herdship Farm	DL12 0YB	20 miles/ 53 min.	34 miles/ 1 hr 13 min.	40 miles/ 1hr 24 min.
Lune Head	DL12 0PB	16 miles/ 40 min.	31 miles/ 1 hour	36.5 miles/ 1 hr 9 min.

Information from the AA

Appendix VI- Effect of Meal Breaks on Rural Services

Whilst visiting Ambulance Headquarter members of the CDPCT PPI Forum took part in a real time simulation exercise as used by call centre trainees. The example given was for a Category A call from Westgate, Weardale. The simulation showed that at that particular time there was no ambulance available. The nearest ambulance was on station two miles away but the crew were on a meal break and all other ambulances were in use.

Because this was a simulation it was not possible to demonstrate which of these ambulances would be stood down from a lesser emergency to be diverted to Westgate, however, the crew on meal break two miles away would not have been alerted. The category A target time could not have been achieved.

Appendix VII a),b),c) The incident at Bellingham Northumberland
Appendix VII a

MAN'S AGONISING EIGHT-HOUR WAIT

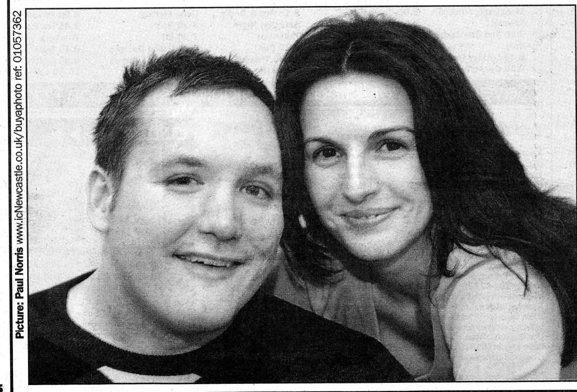
But the NHS insists that it met its targets

By Ben Guy
(01434) 600556 ben.guy@ncjmedia.co.uk

THE National Health Service took eight hours to get a seriously-ill patient to hospital – but everyone involved hit their targets, say health chiefs.

Last night Wesley White, of Bellingham, Northumberland, said his ordeal highlighted the failings of emergency cover in rural areas.

Full story: Page 5



Picture: Paul Norris www.icNewcastle.co.uk/buyaphoto ref: 01057362

Damages bid after holiday tragedy

THE family of a young man left severely disabled after he was knocked down by a priest during a holiday to Rome is taking legal action.

James Kennedy, who was a keen sportsman before the accident, was in a coma for 10 months and now needs round-the-clock care.

Now his family hope to win a compensation payout to improve his quality of life.

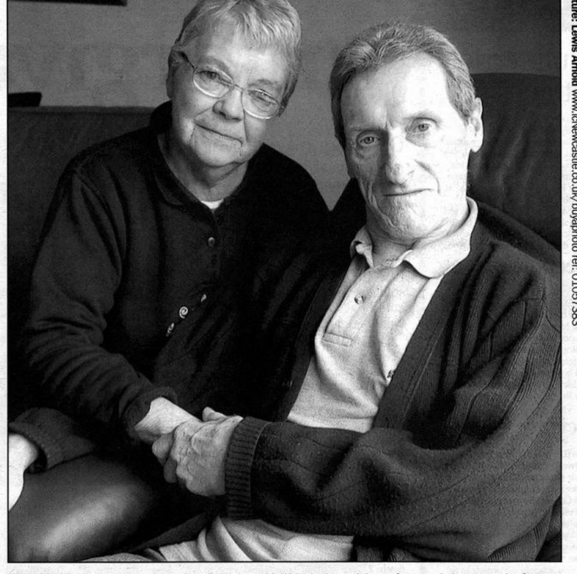
Last night his fiancee Louise Liddon said: "It has been really difficult and I didn't really think I could handle it."

Full story: Page 3

Appendix VII b

Seriously-ill patient slams cuts in rural health service

Man left in agony for eight hours



Picture: Lewis Arnold www.icNewcastle.co.uk/buyaphoto ref: 01057383

EMERGENCY: Wesley and Jan White from Bellingham. Mr White had to wait hours for an ambulance to arrive from Newcastle after suffering agonising stomach pains which later led to him having his appendix removed.

By Ben Guy
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A SERIOUSLY-ILL man who had to wait eight hours for the hospital treatment he needed said yesterday he was failed by rural health care services

When Wesley White, 63, woke up in the early hours of the morning with severe stomach pains at his home in Bellingham, Northumberland, his wife Jan was quick to call NHS Direct for help and advice.

She made her first call at about 5.30am on Saturday, February 2, by which time her husband was already in agony, but it was 2pm that afternoon before he got to hospital.

Health service bosses last night insisted all targets were met.

But Mr White, of Reenes Way, who later had to have his appendix removed, said: "The time it took is just unbelievable and I am very angry. I am not a vindictive person, but I would like to see something like this happen to one of the people who make the stupid health service policies to make them see sense.

CONCERNED: Jim Brownbridge

"My wife rang NHS Direct at 5.30am, but now I just wish I had dialled 999 straight away. If my appendix had burst I would have been a goner. In those situations, minutes can make a difference, let alone the hours I had to wait.

"They have cut rural ambulances and out-of-hours doctors and there is a chance that it could kill somebody."

Mr White described the pain he was left in as agonising, and added that the ordeal had been just as bad for his wife.

After Mrs White called NHS Direct, she spoke to an out-of-hours doctor, who had to travel from Gosforth, Newcastle, and did not arrive until 9.45am. Mr White added: "The thing is that none of the professionals involved are at fault – it is the system and the policies that are wrong.

"It needs at least a local on-call doctor and possibly an ambulance, which we no longer have, to stop this happening again."

After assessing Mr White, the doctor called for an ambulance, which arrived from Wideopen, North Tyneside, about 35 miles away, at about 12.15pm.

But because that ambulance was manned by an urgent care crew, they were unable to administer morphine, and so a further ambulance and paramedic had to be called, arriving at 12.30pm.

By that point Mr White was in too much pain to be transported to hospital by road, and the Cumbrian air ambulance was called, delivering the patient to the Royal Victoria Infirmary (RVI) in Newcastle at 2pm.

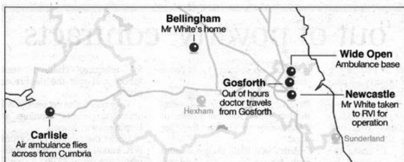
Mr White, who had his appendix removed the following Tuesday and is now at home recovering, said: "The service is totally inadequate. Having an ambulance or an on-call doctor here would have made all the difference.

"I just want this to be put into the public domain for the sake of other people who might not make it, thanks to these stupid policies."

His neighbour Jim Brownbridge, 76, said: "It is absolutely ridiculous. The local NHS is supposed to be hard up yet the cost of the services on that day must have been massive. It could have been avoided.

"If Bellingham still had an ambulance and doctors in surgeries out of hours, he would have been taken far earlier in the day."

Comment: Page 10



TIMELINE

3am, Saturday, February 2 Mr White wakes up with severe stomach pains.

5.30am Mrs White calls NHS Direct explaining that her husband is seriously ill and needs a doctor. She calls again at 7.30am and 9am.

9.45am Doctor arrives at their home from Gosforth and decides Mr White needs an ambulance.

12.15pm First ambulance arrives, but is unable to administer morphine so second ambulance is sent for.

12.30pm Second ambulance arrives, but Mr White is deemed too ill to travel by *road and so Cumbria air ambulance is* called.

2pm Mr White arrives at the RVI in Newcastle in the air ambulance.

Following a number of scans and tests, Mr White has his appendix removed at 12.30pm on Tuesday.

BACKGROUND

Out-of-hours cover delegated

FAMILY doctors were able to opt out of providing out-of-hours care and hand the responsibility over to primary care trusts after the Government brought in a new contract in 2004.

In Northumberland, all 53 GP practices opted to delegate out-of-hours responsibility to Northumberland Care Trust, which commissions the service from Northern Doctors Urgent Care.

This provides out-of-hours care from its Gosforth base between 6.30pm and 8am on weekdays and from 6.30pm on Fridays to 8am on Mondays.

Bellingham lost its ambulance in 2006 under plans by the North East Ambulance Service to close remote stations. Seven stations lost ambulances, which were replaced by community paramedics to provide round-the-clock cover and call for an ambulance to take seriously-ill patients to hospital.

More than 900 Bellingham residents signed a petition against the change. Many feared a single paramedic would not be able to provide adequate cover and were also concerned waiting times for ambulances would increase.

● DESPITE the time it took to get Mr White to hospital, all the groups involved in attending to him hit their targets for acceptable service.

Both the ambulance and out-of-hours doctor's service are commissioned by the Northumberland Care Trust, and a spokeswoman said that all targets had been met.

She added: "We monitor the contracts for both Northern Doctors Urgent Care and the North East Ambulance Service who have to meet national and local targets and quality standards.

"We are sure that those organisations will be looking at the issues involved in this case.

"Both have established mechanisms that patients can use to raise any concerns they may have."

A spokeswoman for North East Ambulance Service NHS Trust said: "We received a call at 10.04am on Saturday, February 2, from an out-of-hours GP to a patient in Bellingham suffering from abdominal pains.

"An urgent care crew was dispatched at 10.18am to an 'urgent' call.

"Urgent calls are classified as patients referred to us by a GP who has decided that they require admission to hospital.

"The GP decides how quickly the patient needs to be admitted and this will usually be within one-hour intervals.

"After arrival and assessment, our crew decided that the patient's condition had deteriorated and required substantial pain relief.

"Urgent care crews are not licensed to administer pain relief and as such felt it in the best interest of the patient to call the air ambulance."

A spokesman for Northern Doctors Urgent Care said: "We are unable to comment on individual cases.

"However, we can confirm that 100% of responses that Saturday, which is our busiest day of the week, fell within target times set by the Department of Health.

"This is well ahead of Government requirements that 95% of responses should fall within these times.

"Overall, we have a strong performance record in West Northumberland.

"For example, average response times between triage and a face-to-face consultation with a doctor was 61 minutes over the six months ending October 1, 2007, ahead of Government targets of 120 minutes, while response times for routine cases were 99 minutes, ahead of a target of 160.

"These responses are comparable with the urban areas we cover."

Appendix VII c

The Journal

Worrying tale of patient's wait for help

ANYONE taking even a cursory glance at the way Northumberland man Wesley White's serious medical emergency was dealt with can see it was not exactly a textbook operation.

Yet according to those seemingly all-important Government targets, everything went perfectly.

The fact that this means it is, apparently, acceptable for it to take almost eight hours to get someone from Bellingham to a hospital in Newcastle seems not to be an issue to Northumberland Care Trust.

We have no doubt that all of the individuals involved did their job effectively and efficiently.

Many will, however, raise an eyebrow over the system within which they were working.

One locum doctor, two ambulances, the NHS Direct service and a helicopter were involved in getting Mr White to Newcastle's Royal Victoria Infirmary.

There, the "front line" NHS staff continued the good work – assessing his condition before eventually operating and removing his appendix.

Both the ambulance and out-of-hours doctor's service were commissioned by the Northumberland Care Trust, where a spokesman said that all targets had been met.

So does that make Mr White's experience acceptable?

He doesn't think so. And neither will most other people who read about his ordeal today.

Targets make sense when you are sitting in an office crunching numbers or making sure "the system" runs the way your political masters decree it should.

The real world – as far as the health service in rural areas is concerned – is very different, and more than a little worrying.