

## County Durham Overview & Scrutiny Committee RURAL AMBULANCE SERVICES

### 1. Introduction

In September 2006, the former Durham Dales PCT, following public consultation agreed to modernisation of the rural ambulance service provided by North East Ambulance Service (NEAS) in the Teesdale and Weardale areas.

The modernisation approved comprised:

- Removal of standby\* working practice
- Recurring investment of £254k to introduce a 24/7 community paramedic service

\*out of hours oncall by inhours crew

The closure of the two rural ambulance stations at Middleton and St Johns Chapel was deferred until it could be considered that relocation would not have a detrimental effect on service provision.

A year long monitoring exercise ran from December 2006 to December 2007. The key headlines from this and further discussion and concerns from the local communities can be seen at Appendix 1

An interim report was submitted to Commissioning Directors in February 2008, and County Durham Overview and Scrutiny Committee in March 2008

Subsequent discussions with community stakeholders identified continuing inequities and poor performance within the service. From public and stakeholder meetings and feedback received, options for each Dale were constructed with the help and support from both GP Practices in the two Dales, NEAS, and the paramedic crew.

### Implications and risks

A number of initial options were considered, including remaining as 'status quo'. Attached at Appendix 2 there are three options that have been considered more fully. Option 3 is fully supported by the clinical leaders in the

Dales, and shared with the rural communities. The feedback from Teesdale from the meetings is more supportive of their service model, However Weardale continue to have concerns about the ambulance base and the lack of a full 2x 24/7 service model.

It is anticipated that it will take up to two years from a decision to fully implement both options due to recruitment and training programme requirements, and so anticipate part year costs up to 2011/12.

The new proposed service model also provides a platform from which further service integration, particularly for local access to urgent and out of hours care can be enhanced. However this is dependent upon recruitment of trained paramedics, or suitable trainees referred to above.

### 3. Recommendations

The Board is asked to consider the service improvement potential of the two proposals for Teesdale and Weardale, and approve:

- The preferred option 3, with a phased investment profile anticipated to have a full year effect in 2011/12.
- Further work be undertaken to confirm the phased costs up to 2011/12
- a new stakeholder group, including local clinical and political leaders and community representatives who will receive information and feedback on the implementation of the new service models.

### 4. Author and sponsor director

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 Date: August 2008

Document management				
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Does this paper provide evidence against any of the areas the PCT is required to demonstrate assurance in eg WCC, ALE key lines of enquiry or NHS national standards? If so which ones? WCC, Access targets for Cat A/CAT B, Healthcare in rural communities				
Version	Date	Summary	Owner's Name	Approved

## Appendix 1

### Headline Information (December 2006-December 2007)

Key Area	Teesdale	Weardale	Total	Comment
No Cat A responses (patients who are/or maybe life threatened and who would benefit from a timely clinical intervention)	Highest monthly demand (50)  Lowest monthly demand (21)	Highest monthly demand(12 )  Lowest monthly demand (1)	448	NEAS advise of low levels of demand relative to population size
No Cat B responses ( require urgent face to face contact/clinical attention but not immediately life threatened)			852	NEAS advise of low levels of demand relative to population size
No Cat C responses( not require an immediate or urgent response by blue light and may be suitable for alternative care)			87	NEAS advise of low levels of demand relative to population size
Call Connect (Cat A performance)	DL12 0 = 5.7% (40.9%) DL12 8 = 68.9% (47.4%) DL12 9 = 50% (9.5%) DL13 5 = 2.1% (4.9%) DL2 3 = 35.7% (20.5%)  (2005/06 in brackets)	DL13 1 = 60% (41.75) DL12 2 = 38.3% (16.7%)  (2005/06 in brackets)	N/App	National Target 75% Cat A response time Weardale 43.8% (21.7%) Teesdale 46.9% (31.8%) 06/07 (05/06) Majority responses in rural areas well in excess of service average although significant improvements seen overall
Response Times (Cat A) Night Times	Max c12 mins Min c8 mins Av c13 mins	Max c35 minutes Min c7 minutes Av c13 mins		Service average <7 minutes  Majority responses in rural areas well in excess of service average although significant improvements

				seen overall
Response Times (Cat A) Day Time	Max c10mins Min c7mins Av c11mins	Max c 23 minutes Min <2 minutes Av c 11minutes		Service average c7minutes  Majority responses in rural areas well in excess of service average, although significant improvements seen overall
Use of Dales vehicle within Dale	73% (27%)	43% (57%)		( )This reflects the extent of pull on the vehicle out of the Dale for Cat A calls
Conveyance Rate	62%	68%		Reflects positive increased rate of management of patient presentations out of hospital eg community paramedics

## Conclusions

Activity is advised as very low for both Dales which presents challenges, not only in the potential for statistical skew, but also in configuring and rationalising some of the stepped changes and investments that need to be considered to achieve relatively small further improvements, without considering other benefits to be achieved from utilising any additional investments in skilled resources.

From the date of the original investment there has been significant levels of improvement with two of the postcode areas in Teesdale (DL12 0 and DL13 5) showing deterioration. Weardale has been a significant gainer on Cat A performance. However performance is poor in comparison with performance achieved in urban areas overall.

Response times at night are poorer with greater inconsistencies, whilst the service overall remains consistent.

The rural communities are made more vulnerable and poorer response times are worsened reflecting workload outside the Dale without adequate back up and support services.

Reduced conveyance rates cannot be interpreted as solely the result of a community paramedic service, however it should be seen that the availability of a local (limited) urgent care service has contributed to this improvement.

During the period from December 2006 to date a number of outcomes could be observed/derived from the changes as follows:

- Potentially more staff available to work on rotation
- Potentially more opportunity for integrated working with other healthcare services in the rural communities, particularly urgent and out of hours care.
- Improved training and support will continue to reduce the % of patients conveyed to hospital, although further improvements may be less marked.
- Activity remains very low, providing greater potential for integrated working whilst recognising that the emergency response is the key priority for the ambulance service
- The local communities value the presence of the paramedic service

However it could also be seen that the local community has a number of concerns as follows:

Concern	Response
Vulnerability of communities with inadequate back up support. The vehicles for the rural areas are regularly pulled out to provide services to populations outside the two Dales and leaving the rural populations with no cover	Both Option 2 and 3 provides resilience both in terms of additional vehicle and paramedic cover within the Dale – a greater resilience is offered with Option 3 as the vehicles will operate fully within each Dale.
Weardale/Teesdale support 24/7. Significant community concern over the heightened sense of isolation resulting from road configuration and the impact of bad weather	The 'second' vehicle operates 12/7. The PCT will work with NEAS to ensure the cover is over the 12 hour period shown to reflect greatest demand across the seasons. Levels of demand historically do not warrant the recommendation of two 24/7 vehicles.
Closure of rural ambulance stations	This is NEAS estate. The stations are not planned to close. There is potential to increase usage of the stations as part of a next stage piece of work on outreach urgent care subject to further evaluation and costing.
Operational base for paramedic crews	The PCT has concentrated on a service model that provides care across the wider Dales areas with services and cover up the Dales as part of this model. Vehicles will begin and end shifts at Barnard Castle and Stanhope but a vehicle will work across both Upper Teesdale and Upper Weardale as part of the service model.
Post code areas particularly around Upper Weardale and the Middleton area, receive a very low Category A performance response.	Option 3 particularly supports a community based integrated service model which will allow vehicles to work across both Dales in hours and will be operational from Stanhope/Barnard Castle out of hours
Ambulances supporting conveyance out of	Negotiations with NEAS confirm that vehicles

the Dales	conveying out of the Dales will be returned promptly unless they are the closest unit to respond to another Cat A call whilst on route back.
Speed of implementation	This will be as fast as recruitment/training programme allows which may be up to 2 years. However there is a positive recruitment campaign in progress which indicates we will be in a position to deliver a phased implementation from 2008/9
Local knowledge	Paramedic training does not begin until 21years. NEAS have confirmed a commitment to work with local schools to raise the profile for future job opportunities for youngsters and local practices have agreed to advertise paramedic training opportunities. Skilled and knowledge existing staff will work on rotation with new recruits to increase local knowledge.
Equity of Service/Performance Issues remain over the distance the rural population needs to travel to receive urgent care (other than the care available from the two GP Practices in the areas), particularly out of hours.	The PCT acknowledges the performance in Cat A is poorer – but is and will continue to work with NEAS to continue the improvements made. The introduction of a community paramedic service offers the rural communities an urgent care service that is not available in urban areas.

Options Appraisal

	Option1	Option 2	Option 3
<b>Outline</b>	Status Quo ie 'control option'	Fully integrated community paramedic service with shared back up conveyance	Fully integrated community paramedic service with dedicated back up conveyance
<b>Detail</b>	24x7 traditional paramedic crew (1 paramedic and one driver/emergency support worker) 1 vehicle per Dale starting and finishing from rural ambulance station but operating from Barnard Castle/Stanhope. Vehicles and paramedics leave locality to respond appropriately to call priorities and transport to hospital Rural communities receive back up from wider NEAS service out of area	Single community paramedic service based in rural communities 12/7 plus 24/7 service traditional crew(see Option 1) based at Barnard Castle and Stanhope.  Single paramedic back up transport as a retained resource 24/7	Teesdale 24/7 and 12/7 vehicle staffed by double paramedic crew  Weardale 24/7 staffed by double paramedic crew and 12/7 4WD by single paramedic crew  Vehicles start finish at Barnard Castle/Stanhope. The 12/7 provide service to Middleton/Upper Weardale communities  Dedicated 12/7 provides back up resource in area
<b>Pros</b>	Maintains current performance status (where improved)  Continues valued support for service in local communities  Some potential to work more fully as integrated service  Platform to explore opportunities for implementing successful service models elsewhere	Fuller development of community paramedic role.  Service visible and valued in community  Improves performance across all postcodes  Enhances urgent care in rural area and reduces transport out of area for urgent care  Retains more resource in area and reduces vulnerability and exposure for local community  Increased resilience and enhanced integration	Fullest development of community paramedic role  Service visible and valued in community  Improves performance across all postcodes  Greatest enhancement of urgent care in rural area and reduces transport out of area for urgent care  Retains greatest resource in area and reduces vulnerability and exposure for local community  Most increased resilience and

		Reduced recruitment and retention issues	enhanced integration  Model of service receiving support from both local clinicians and paramedic crews  No anticipated recruitment and retention problems
<b>Cons</b>	Continue to see poorer performance across some postcodes  Contributes to underachieving PCT performance  Service and community exposed in event of emergence/urgent care requirement  Service model not supported. Difficulties in recruitment and retention of paramedic staff	Requires significant investment  Requires additional staff – increase 10 paramedic staff  Requires back up agreement  Disruption to urgent care work due to emergency response priorities and limited numbers of community paramedics on rota  Vulnerability and confidence of response time for shared vehicle	Requires most level of significant investment  Requires additional staff – increase 13 paramedic staff  Requires back up agreement  Lesser disruption to urgent care work due to emergency response priorities given numbers of community paramedics on rota  Discreet vehicles reduces vulnerability for cover
<b>Estimated Response Times</b>	As now	Improve performance to 50-50.9%	Improve performance to 50-50.9%
<b>Recommended</b>			<b>Option 3</b>



