Briefing to Staffordshire Councillors Regarding Review of Ambulance CAS Points

Appendices Attached:
Appendix A - WMAS Statistical Data

The following document has been pulled together by way of a briefing for Scrutiny Committee members following regarding ambulance provision within Staffordshire which we hope will be useful to members.

Staffordshire led the country in designing a new, more efficient way of operating when it introduced the 'make ready' system in the 1990s. This was rolled out to the rest of the West Midlands following the merger of Staffordshire in the 2000s. Today West Midlands Ambulance Service has a network of 15 large Make Ready Hubs; in Staffordshire these are based in Stoke, Stafford and Lichfield. When the move was made, there was initially also a network of rapid response vehicles (RRV), usually 4x4 cars, that worked from strategic locations known as Community Ambulance Stations (CAS), very often in market towns across the West Midlands. This was largely due to the call categorisation system that we were obliged to use at that time that concentrated on getting to calls very quickly, but not necessarily with the right resource.

A good example of this would be a stroke patient; an RRV would get there in under eight minutes but, if the patient was FAST positive, what they actually needed was an ambulance to take them to a hyper-acute stroke unit for immediate care – we aren't able to transport patients by car. Doing so can make a huge difference to the life of the patient going forward. What happened in the West Midlands to some extent, but much more so in other areas of the UK, was that the car would wait sometimes for hours for an ambulance to arrive to take the patient to hospital. This severely limited the ability of the hospital to provide the necessary care. While we hit the statutory target, the patient didn't get the care they needed, which clearly was not appropriate.

With the introduction of the Ambulance Response Programme in 2018, WMAS firstly reduced and then got rid of entirely, it's fleet of cars – at one point we had over 100 operating each day! These were all replaced by ambulances. As that move took place, we reduced the number of CAS points as they were simply not being used. By 2020, we were down to just 13 sites. The money saved from not having the CAS sites was invested in additional staff and ambulances.

As you will be aware, the last few months have been extremely challenging; in July, we saw demand at levels that we could not possibly have envisaged. We set a new record for 999 calls on 19th July when we received and answered 6,418 calls in a 24-hour period! When you consider a busy day at the moment should see us receive circa 4,000 calls, you can see the level of challenge we face.

Another factor that has badly affected us over recent months have been the delays handing patients over at hospital. As you will be aware, we are supposed to do so within 15 minutes of arriving at an A&E Department. Unfortunately, many of the hospitals in our region are extremely challenged and this has led to some very long delays. Indeed, in recent weeks, we have had crews wait over 11 hours to hand their patient over. During July, there were many days when we were losing over 1,000 hours of ambulance time while crews waited to hand over patients – that is the equivalent of taking 85 ambulances off the road and putting them in a car park and deciding not to use them that day. You can only imagine the challenges this brought us.

To put it into context, in July 2019 (pre pandemic) we lost 4,818 hours during the month of July due to handover delays. In July 2021, we lost 14,866 hours! Almost 7,000 patients waited over an hour to be handed over, many of them having to be kept in the back of the ambulance. Not only was this

poor for patients it put an intolerable strain on our staff with many regularly finishing their shift late, often to the tune of three hours on top of a 12 hour shift. No other NHS staff face such situations.

The Trust moved to REAP 4 (the highest level of concern) for the first time in its history. At one point, all ten English ambulance services were at REAP 4. Currently, only WMAS and one other Service have de-escalated to REAP 3. You may also have seen in the news that three services in other parts of the country are now receiving military assistance due to the level of challenge they face. Thankfully demand has calmed down a bit since the latter half of July, though it remains above expectations, but that is no different to any other part of the NHS at the moment.

As a result of the above, we have implemented a number of changes to protect patients and our staff. One of the biggest changes has been the introduction of the Clinical Validation Desk. Calls continue to be triaged by our call assessors in the normal way: they are divided into four categories – Cat 1 is the most serious and includes a patient in cardiac arrest. Category 2 included heart attacks and strokes while Category 3 are classed as 'urgent' and Category 4 as 'non-urgent' by NHS England. Under the new scheme, a number of Category 3 and 4 calls are further examined by a team of advanced paramedics in our control rooms. The aim is to take these lower category calls and make better use of the alternative pathways that are available in the NHS.

This could be through directing occupational therapy teams, fall co-ordination services or advanced nurse practitioners working in the community to visit the patient instead of an ambulance. Many other calls are being resolved with advice only. The work of the team is expected to reduce the number of ambulance dispatches by several hundred each day purely by arranging for more appropriate healthcare staff to visit the patients. Our 'Hear and Treat' rate has risen from around 5% to 15% each day and may go higher still. This allows us to focus our ambulances on the calls that really need our help and will allow us to respond more quickly.

This brings me on to the next significant area of work, a review of the Trust's CAS sites. Two have already closed – Leominster after it was flooded 18 months ago, and Uttoxeter which suffered a leak. Stourport is due to close in early September. The Operations team will be examining the other ten sites (Biddulph, Leek, Evesham, Malvern, Craven Arms, Oswestry, Market Drayton, Bridgnorth, Rugby and Stratfor upon Avon) over the coming weeks.

There is a common misconception that where an ambulance starts or finishes a shift will have a substantial impact on the area that it is based in. What must be remembered is that as soon as an ambulance is available it will be sent to the nearest available case so that we can minimise the time a patient waits to be seen, something I am sure you would support. This means that vehicles can often end up in rather odd places. Recently, we had a Dudley ambulance in Malvern and a Hereford vehicle that had gone to Birmingham Children's Hospital then getting a case in Birmingham itself as it was the nearest ambulance available.

If you look at the data from the first six months of the year, for the three CAS sites in Staffordshire, you find the following:

Biddulph
Total cases: 40,954
Cases attended by the Biddulph ambulance: 1,353
Percentage: 3.3%

Leek
Total cases: 44,086

Cases attended by the Leek ambulance: 1,365
Percentage: 3.1%

Given what I have already outlined in regard to demand, it is now rare, if ever, that the crews who work at the CAS points ever get back to the site other than for their meal break or at the end of their shift. Like the crews based at the Hubs, they literally go from one emergency to the next, 24 hours a day; they are no longer sat on a station anywhere in the region waiting for a call. Therefore, one of the questions we are duty bound to consider is whether it is appropriate for the Trust to spend precious funds on buildings that are rarely used when these could instead be spent on additional staff and vehicles; the things that save lives?

Currently, less than 50% of patients seen by our emergency crews are taken to hospital. This means that, for example in Biddulph, in roughly 20,000 occasions for the time period above, an ambulance was in the area available to respond, even though it wasn't the ambulance that is based in the town.

In cases where a patient needs to be taken to hospital, they will inevitably end up in Royal Stoke University Hospital (RSUH) depending on the patient's condition and location. If we assume that it was the Biddulph ambulance that took them to RSUH, then clearly it would not be in the town ready to respond to another call. Quite rightly you would not expect us to wait for the ambulance based in the town to finish with its current patient before we responded to any subsequent call that is waiting in the area. You can therefore see how the above figures come about.

Whether we make any changes to the number of CAS sites or not, we would not decrease the number of staff or ambulances in the area, just change where they start or finish a shift.

We recently closed a CAS site in Uttoxeter in Staffordshire and relocated the ambulance to Stafford Hub. Today, when that crew come on shift, they will get into an ambulance that is fully fuelled, clean, stocked and ready for the full shift. In contrast, when they were at the CAS site, twice a day the crew had to go to Stafford to exchange their vehicle for a newly stocked vehicle, reducing the amount of time that it was available to respond to incidents.

Currently, there are only two permanent members of staff at Leek and seven at Biddulph – you need ten to operate an ambulance 24/7. This means that each day we have to move staff from other locations to ensure the ambulance can operate. Should we move these vehicles to Stoke Hub, then fewer staff will be affected by this than currently are.

The welfare of staff is clearly one of our highest priorities, particularly when they are under so much pressure at the moment. By having the ambulance based in Stafford, we will be better able to support the 10 staff previously based in Uttoxeter. A manager is available at the Hub 24/7, whereas the staff in Uttoxeter would only have seen one when they went to the hub to change vehicle.

The Trust has discussed the review with staffside colleagues and wrote to all of the staff affected last week. What we have said to both staff and their representatives is that should a CAS site close we will do what we have in Leominster, Uttoxeter and Stourport and work with the staff so that they can choose which Hub they move to and if they wish to stay on a current roster, then that will also be accommodated.

I am sorry that the briefing is anything but brief, but I hope it provides a useful update about the current challenges and context about the review currently being undertaken. If I can finish by assuring you that we will only make a change if we are convinced that it will benefit patients. WMAS

continues to be the highest performing ambulance service in the country and we aim to ensure that that position continues to be the case.

Yours sincerely,

Murray MacGregor
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