

Kent Health Overview & Scrutiny Committee

Emergency Care Pathway Review

SECamb Report

1. How will the public's experience of the ambulance service change as a result of the development of 24/7 specialist units?

Direct access to specialist centres is designed to improve patient outcomes in line with best practice. Whilst initial journey times to the specialist units may be longer than currently, this should negate the need for patients being transported to hospital, and then subsequently requiring a secondary transfer to a specialist unit. For patients, this means that they should receive the specialist care that they require sooner.

2. How will the training and job descriptions of paramedics be changing to take account of these changes?

The Trust has plans in place to train more paramedics at post-registration level, in both primary and critical care. These are called Paramedic Practitioners and Critical Care Paramedics. The Trust's workforce plan considers wider workforce change, with various different grades of operational staff, linked to service delivery to meet patient need.

3. How else will the ambulance service be changing in light of these service developments?

The Trust will continue to work to ensure that staff are equipped with the appropriate education, skills and understanding of complex conditions, including being aware of the impact of longer journey times.

SECamb are undergoing wide workforce change, with a wider ranging skill mix being introduced, linked to patient need.

Work will be undertaken in conjunction with specialist centres and networks to review and audit the outcomes on an ongoing basis.

4. How will it be decided where to take a particular patient?

Appropriate pathways and parameters will be agreed in close liaison and negotiation with clinical networks and commissioners. This information will be cascaded to staff, enabling them to take the patient to the most appropriate receiving unit. The use of modern technology will assist in ensuring the patient is taken to the correct specialist centre. All vehicles will be equipped with a telemetry system that allows the patients details to be sent to the receiving hospital which allows them the time to set up the necessary teams for the immediate treatment required upon the arrival of the patient.

5. How is this decision communicated to the patient, where possible?

As with current procedures, crews will endeavour to keep patients, as well as relatives and carers, informed as to where they will be taking them, recognising that this may not be to the nearest hospital.

6. What is Protocol C?

Protocol C is a more effective method of CPR that involves giving 200 chest compressions before delivering a shock from a defibrillator, followed by a further 100 compressions after the shock. This is in contrast to the previous method of resuscitation, which saw alternating breaths and compressions given before delivering a shock. From a clinical outcome perspective, this method has delivered improved levels of Response of Spontaneous Circulation (ROSC) for patients, leading to more lives being saved.

7. What information can you provide about the ambulance service travel times to these specialist centres from different parts of Kent?

We have undertaken an analysis of travel times using GIS software to map and model one year's activity for Kent PPCI patients, to identify potential ambulance implications. The implications of additional travel to a primary specialist centre will be similar for stroke, as it is for PPCI, though the centres might be different.

However, as mentioned above, the main issue is not necessarily the additional travel times to a specialist centre, but that the patient will be directly transferred to the most appropriate receiving unit. This will potentially lead to an improved outcome for the patient, at a centre that is best equipped in terms of staff skills and resources. In the case of stroke and PPCI in particular, time is a significant factor for good outcomes.

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