Patchwork privatisation or progress?

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Introduction

There has been much debate regarding the use of private providers by ambulance Trusts, most recently the report in the Newsline section of *Ambulance UK* [1]. Horror stories abound ranging from private ambulance companies having spurious qualifications and backgrounds to substandard equipment and a paucity of the drugs needed to treat emergency patients.

Whilst it is impossible to vouch for all private providers, we are in a position to comment on one of them, Event Paramedics Ltd (EPL) who we joined as Operations Managers after a cumulative 30 years in the National Health Service (NHS).

By writing this article it is hoped that many of the fears and concerns that exist with regard to the increasing trend for using private sector ambulances can be dispelled.

Background

Across the United Kingdom (UK) ambulance service demand is rising by approximately 6% per annum equating to an extra 250,000 responses [2]. In 2007-08 the percentage of category A incidents that resulted in an emergency response arriving at the scene of the incident within eight minutes was 77.1%, the highest rate recorded [3].

In addition to heightened demand, staff shortages pose a serious problem. Qualified, clinically experienced paramedics cannot be plucked out of thin air.

Traditionally, staff joining the ambulance service could work their way up with experience and additional training culminating in a paramedic course accredited by the Institute of Health Care Development (IHCD) and Health Professions Council (HPC) registration. However, this route is no longer available to new entrants who must now undertake an approved, full-time course in paramedic science at university over a two to three year period [4].

This reflects the move from training to education when benchmark standards for paramedic education were formalised [5].

Traditionally, shortfalls in staffing have been compensated for by staff working overtime. This, however, is not always either possible or ideal. The Welsh ambulance service were criticised this year when it was revealed that up to 40 shifts a day were being covered on overtime [6]. Concern was expressed by Unison's head of health in Wales, Dave Galligan, that the welfare of staff was being put at risk by excessive amounts of overtime being worked [6]. This is particularly concerning when considered in the light of the European working time directives. The directives limit an average of 48 hours per week which a worker can be required to work and, although individuals can currently opt out if they wish, this is likely to be phased out when they are progressed through European Parliament in late 2008 or early 2009 [7].

Trusts are also under financial constraints and usually have set overtime budgets. A whistle blower from the Great Western ambulance service revealed that the Trust is offering staff a £100 bonus to work overtime at nights and weekends [1].

When this is added to the fact that most overtime is payable at time and a half under Agenda for Change [8] it can be seen that overtime costs ambulance Trusts a vast amount of money which could be better directed elsewhere, for example, staff recruitment and training. This dilemma is, however, an emotive one. When the Welsh ambulance service imposed a limit on overtime due to financial constraints it resulted in a 90% reduction in ambulance cover [6].

It can be seen then, that the problems of excessive overtime costs and a shortage of paramedics are ones ambulance Trusts needed to address immediately.

In 2005 the Department of Health (DoH) made recommendations for how ambulance services could operate both more efficiently and effectively including "*in outsourcing appropriate support services where this will improve efficiency and quality*" [2].

The DoH also stated that they would "*consult the independent ambulance sector, the NHS and Healthcare Commission to identify the most appropriate system for accrediting independent ambulance providers*" [2]. These factors, together with the introduction of the eight minute response time for category A calls goes some way to explain why ambulance Trusts began to use private providers for frontline work.

Having discussed the background to the use of private ambulance providers it is now necessary to address some of the concerns raised by both NHS ambulance staff and others. It must be stressed again here that we have been able to use only EPL as an example.

The accreditation process

EPL currently have contracts to provide rapid response vehicles (RRVs) with NHS ambulance Trusts. Before any contracts were considered the company had to undergo rigorous audit and inspection by both senior managers from the relevant Trusts and accreditation by the Ambulance Service Association (ASA). This was an in-depth and lengthy process but one which has immense value in ensuring that proposed private providers are, in fact, as professional as they purport to be. This process was welcomed by EPL and is one which MUST be adopted as standard practice by ambulance Trusts in order to ensure that patients are not put at risk.

Criteria for employment

EPL employ both permanent staff and those on a sub-contractor basis. ALL staff are subject to an enhanced Criminal records Bureau (CRB) check without exception and ALL are either State Registered Paramedics, IHCD Ambulance Technicians or Emergency Care Practitioners (ECPs).

Professional qualifications

Almost all paramedics working for EPL have qualifications over and above that of state registration. These currently include MSc in Cardiology, MSc in Advanced Health Care Practice, BSc (Hons) in Pre-Hospital care, Diploma in Pre-Hospital Care, Diploma in Immediate Care Royal College of Surgeons (RCS) Edinburgh (Dip IMC RCS Ed), RCS Medicine in Remote Areas qualification, Pre-hospital Trauma Life Support (PHTLS) including instructor status, Advanced Life Support (ALS) including instructor status, Paediatric Advanced Life Support (PALS), Travel and Tropical Medicine qualification, Certificate in Education (Cert Ed), City and Guilds D32/D33 Vocational Assessors Award, City and Guilds 7303 Teaching Award, Major Incident Medical Management Support (MIMMS) and offshore medics qualification.

In addition to the above one member of the management team and one member of staff sit on the British Paramedic Association (BPA) College of Paramedics Research and Audit Committee, thereby ensuring that the company remains current regarding emerging evidence based best practice issues in the pre-hospital arena. Members of the management team are also members of the British Trauma Society (BTS), RCS Faculty of Pre-hospital care and the BPA College of Paramedics. A member of the management team also has 14 publishes to date and she and another member of staff write on a regular basis for the *Emergency Medical Journal* (EMJ) '*from the pre-hospital literature*' column. A member of the management team also trained as an HPC inspector/visitor.

This is not intended to be an exercise in self-congratulation. Rather it is testimony to the level of excellence of the staff that work for EPL and will hopefully go a not inconsiderable way to reassuring NHS staff, patients and others who may harbour any concern regarding clinical standard and validity.

Equipment and drugs carried

Claims have been made that private providers carry less or substandard equipment or drugs than NHS ambulance services [1]. This is certainly not true in the case of EPL. Much of the equipment carried is often superior in diversity and quality, for example, tympanic thermometers, water gel burns dressings and adult bone injection guns which are not always routinely carried by NHS ambulances, often due to cost.

Paediatric equipment in particular is far more varied on EPL vehicles, for example, paediatric endotracheal (ET) tubes down to 2.5mm in size when certain ambulance Trusts carry down to a 6.0mm tube only.

EPL also carry a wider range of drugs than many ambulance Trusts. Examples are cyclazine, Hartmann's, amiodarone for use in cases of pulsed ventricular tachycardia (VT) rather than just cardiac arrest and oral morphine. The only reason these drugs are not used (although it must be stressed that they are carried) is that individual NHS Trusts have requested that EPL staff work under their clinical guidelines and not those of best practice.

Profit versus Patient Care

It is not under dispute that private companies need to make a profit. However, it does not follow that profit must come at the expense of patient care. Quite the opposite. Any private provider who does not put patient care first will not remain viable within the pre-hospital arena. Company reputation travels fast. It was rather contradictory that the whistle blower from Great Western ambulance service when talking about financial

incentives for overtime stated "*it is hard to turn down the offer of money like that, so people are getting burned out*" [1]. Surely burned out staff are not working at optimum capability, a situation brought about by the pursuit of extra money. Quite a surprising comment from a person who accuses private providers of being solely concerned with money.

Do we make a difference?

EPL have made a significant contribution to the ambulance Trusts we have contracts with.

- In August 2008 EPL made a 6.2% contribution to the eight minute response target for category A calls. This is particularly significant when it is considered that this is the percentage by which ambulance service demand is rising per annum [2].
- In October 2008, 83 patients were treated and discharged on scene by EPL staff thereby freeing up front line Trust ambulances which would have otherwise had to respond and deal with these incidents.
- In October 2008 there were 34 instances where EPL paramedics traveled with patients to hospital in Trust vehicles as no Trust paramedic was available. In these cases the clinical condition of these patients warranted paramedic intervention and the Trust crew sent to back up the RRV was either a student paramedic, technician, trainee technician or emergency care assistant (ECA) crew. Again, this is of particular importance when considering the DoH statement that "*patients should be met by the professional best able to deliver the service needed*" [10].
- In October 2008 there was one instance of an EPL paramedic being asked to back up a trust paramedic at the scene of an incident as he did not have access to the drugs he required to treat the patient.

In addition to the above figures, RRVs are very often waiting for long periods of time for an emergency ambulance to arrive at the scene to back them up and transport the patient to hospital. The longest time period in October was three and a half hours, followed by two and three quarter hours. Waiting times of over an hour are regular occurrences. If RRVs were not available to send as an initial response it is without a doubt that in certain cases patients would have suffered.

This article hopefully goes some way to addressing concerns raised such as those raised by Councillor Wannell who states that he was "*horrified that the use of privately contracted ambulances could put lives at risk*" and "*the people of Wooton Bassett require better*" [1].

Any legitimate private provider will welcome a tightening of the regulations and procedures governing private ambulance services and will have no qualms at being subject to scrutiny. Standard procedure for verification should be adopted by all Trusts when considering the use of private providers and will hopefully help to weed out any companies that may put patients at risk.

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