**MONKSPATH PATIENT PARTICIPATION GROUP**

**NOTES OF MEETING TUESDAY 11 APRIL 2017**

*Note: ‘SG’ indicates a member of the PPG’s steering group; ‘C’ means a comment. ‘Q’ means a question, and ‘A’ means an answer.*

**Members who signed in**

M A Collins Michael Evans (SG) David Fereday George Fereday

M E Garbett Tony Green (SG) Muriel Krauth Terry Krauth

David Lassam-Jones Ginny Lassam-Jones Jacky Law Bob Lewis

Vic Lloyd (SG) Susan Lynch Alistair McLachlan (SG) David Page

Dave Perry (SG) Paul Price Clive Raybould Carole Robertson

Linda Shapcott Sheila Stokes Ken Thompson Norman Thorburn

Sharon Wade

**Guest speaker**

Andy Jeynes, Community Responce Manager, West Midlands Ambulance Service

**Practice Manager**

Rachel Critcher

**Apology**

Martin Tolman (SG)

1. **Opening admin**

Tony Green, PPG Chair, opened the meeting at 7.00 pm. He welcomed everyone, forgot to ask for apologies, summarised the agenda, went through the draft notes of the meetings held on 13 December 2016 and 14 February 2017 and since no inaccuracies were identified, sought acceptance of the notes, which members agreed.

1. **Updates on the notes from the two previous meetings**

In the December notes, at the bottom of page 6, it mentioned that “…a speaker on the STP has been invited (for the meeting in February) but hasn’t yet confirmed”. As many members know, the speaker was Mark Rogers, Chief Executive of Birmingham Council, who did confirm he would come, but then had to cancel at the last minute because he was unfortunately off being sacked on the day the PPG met. His role in co-ordinating the development of the Sustainability and Transformation Plan (STP) has since passed to Dame Julie Moore, Chair of University Hospitals Foundation Trust. A new speaker has been booked to speak on the STP at the 13 June PPG meeting: she is Teresa Scragg, Senior Commissioner for Older Peoples Services, Solihull Council. That meeting will also include a hopefully short AGM when the members of the SG can be elected, re-elected or unelected, and others can stand for election to it: all present SG members are white males aged between mid-60’s and mid 80’s, so we would welcome more diversity. Tony mentioned that he would be away in France on 13 June, so Vic Lloyd, deputy chair, would chair the meeting. A few days after the AGM, the new SG would meet and choose from its members who will hold the officer roles (chair, deputy chair, secretary and treasurer for the next year or two. Under the PPG’s constitution, nobody can serve in the same officer role for more than two successive years.

In the February notes, half way down page 2 said an estimated 46 had attended: when all SG members’ estimates were averaged later they came to 50. Three quarters of the way down page 4 said that mergers between HEFT and UHB (hospital trusts) would be in 2022, but it now seems likely that it could be as early as 2018: we’ll keep you posted as this situation develops. Half way down page 5 it says “…public engagement/consultation (on the STP) will probably start sometime in April” but it now seems more likely to start in May. Near the bottom of that page it mentioned that we would try to get the two Solihull MPs to set up a meeting: we have invited them and Julian Knight MP has said he’s willing to attend one of our PPG meetings providing that’s okay with Dame Caroline Spelman MP, but we are still awaiting a response from her.

1. **Presentation and show ‘n tell on Cardiac Arrest, CPR and the use of defibrillators**

Andy Jeynes introduced himself as one of three remaining Community Response Managers for West Midlands Ambulance Service (WMAS) where there used to be six. He did a PowerPoint demonstration, with slides showing the huge area that WMAS covers, and hinted that there might soon be a merger with East Midlands Ambulance Service – we’ll keep you updated when there’s news on this. WMAS performs better than other ambulance trusts. One of the performance targets was to have a trained paramedic in every vehicle and that has been achieved in WMAS. Andy is qualified as a paramedic.

He mentioned that WMAS has a Hazardous Response Team (‘HAT’) that handles incidents involving really dangerous substances. WMAS has the use of four helicopters which are provided free by the FASTAID charity. In many cases where Fire staff were the bronze, silver or gold level operational commanders in an emergency, often WMAS staff now have those roles: all WMAS managers are now trained as operational commanders. There’s a Research Centre for the “chain of survival”: (don’t tell anybody but it’s at Warwick University).

Most heart attacks don’t cause cardiac arrest, though if cardiac arrest occurs it’s usually because of a heart attack. Andy explained that “Cardiac Arrest” is derived from the French words for “heart stop”, but this is misleading: if the heart has stopped altogether the patient dies very quickly. He said if someone’s heart loses its normal pumping rhythm, it doesn’t stop altogether, the large lower part of it quivers (fibrillates). Andy asked us to raise our hands if we think the shock from a defibrillator starts the heart: most of us – including the Chair – raised their hand. Andy explained that most people assume that the brain controls the heart rhythm, but that’s not correct: some specialised cells in the heart’s muscle wall alternate their electrical polarity on a frequent, regular timescale, which normally signals the heart to keep beating: it’s the equivalent of a natural pacemaker. Whilst the heart is fibrillating the ‘pacemaker’ signal can’t get through, so the shock from the defibrillator stops the heart so that the signal to restart pumping naturally can get through.

If you’re among the first on the scene when someone (‘the casualty’) has had a cardiac arrest, the immediate thing to do is to check for danger such as whether the casualty is still in contact with say a live electricity cable: Andy stressed that you are more important than the casualty, since he or she may die despite your best efforts, and it would be pointless if you die as well by trying to save them. If there’s no danger or the danger has been neutralised, look at their face: if there’s no movement and their skin is greeny-grey they may have unfortunately died , but you can verify that by checking for a pulse or testing whether they are breathing at all. If they don’t seem to be dead, test for consciousness by speaking into each ear and shaking the person’s shoulders to get their attention. This is in case the casualty is deaf in one or both ears. Then tilt their head back to check for blockages in their windpipe. Then one of you should start applying cardiopulmonary resuscitation (CPR) while another gets a defibrillator.

CPR is designed to keep blood supplying oxygen to the brain and other main organs. It can’t restart the heart, but can buy time by minimising the damage. Put the casualty on his or her back, put the heel of one hand on the upper chest – between the nipples, then put the heel of the other hand on the first, lean over the casualty so your arms are vertical and straight, then press down hard on the casualty’s chest so you depress it by a third of its height, which will force the heart to pump, and get at least some oxygen to the target organs. Then release the pressure, and repeat the compression. It has to be repeated quickly: you can do it by remembering and following the rhythm of the ‘Nelly the Elephant’ song or the Bee Gees ‘Staying alive’ song, or just by thinking to yourself ‘push/ relax and push/ relax’. Andy demonstrated CPR on a dummy head and torso. Doing this for more than a few minutes will be very tiring so get others around you to take turns doing it. It’s no longer recommended that you try mouth to mouth resuscitation: the CPR should be continuous.

The person who tries to get the defibrillator should, if they know a nearby premises has a defibrillator and is open, run and yell for that to be brought by someone who’s been trained to use it. We know that staff in the smaller of the two Co-op retail outlets in the Farmhouse Way shopping precinct have been trained to use the public access defibrillator (PAD) on the external wall of the store, just round the corner from the cashpoint. Another defibrillator is in our GP surgery and another is in the private health clinic near the precinct. Whilst that’s being brought, ring 999 and ask for the ambulance service, tell them where the casualty is and that a defibrillator is being brought, and an ambulance will be sent.

If all those premises are closed the PAD is the only one that should be accessible. In theory we should ring 999 and ask for the ambulance service, tell them the location code shown on the defibrillator on the one near the Farmhouse Way shopping precinct the location code is **AAB13** – which enables the operator to know where the PAD is - then tell them where the casualty is in relation to the PAD, then ask them to tell us the release code to open the cabinet and release the PAD.

**But Andy said there’s a problem**: the Central England Co-op (CEC) which generously bought the PAD and had the cabinet fitted to the wall has not yet told WMAS the codes to release any of the 68 PADs that it has fitted in the areas that WMAS covers, despite several requests from WMAS. The company that partners CEC in installing the PDs is Well Medical.

The Chair said he would write to the CEC and seek to persuade it to release the codes. He had known about this problem for two weeks or so, and had first told staff in the local CEC retail unit and one senior member of staff had promised she would ring the CEC head office straight away to remind someone to release the codes. That didn’t get any result. So the Chair sent a short message via the CONTACT US link on CEC’s website. Then he sent a letter to the Chief Executive of CEC so that the pressure to act would come from the top down as well as the bottom up. For members’ information the text of the letter follows in italics except that the Chair’s home address and personal email address are replaced by ‘x’s.]

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*xxxxxxxxxxxs*

*Friday 14 April 2017*

*Martyn Cheatle*

*Chief Executive*

*Central England Co-operative*

*Central House*

*Hermes Road*

*Lichfield*

*Staffordshire*

*WS13 6RH*

***FAILURE TO DO THE LAST, EASY BIT***

*Dear Martyn,*

*Central England Co-operative (CEC) has been very generous in funding and arranging the supply of public-access defibrillators (PADs) on the outer walls of many of its retail outlets. If you authorised this, thank you.*

*You may know and understand all about defibrillators and their use, but here’s a brief reminder. When someone’s heart is fibrillating (quivering) and has lost its normal pumping rhythm, only use of a defibrillator can restart it. For those who suffer this when they are out in the community, PADs fill the gap when all the nearby premises in which there is a defibrillator are closed. Each PAD is mounted in a closed cabinet (openable by inputting a unique release code) fixed on the outer wall of a building. The person needing to unlock the cabinet first has to ring 999, ask for the ambulance service, then tell the call-handler the unique location code shown on the front of the PAD and where the casualty is in relation to the PAD, and ask for the release code, so that the PAD can be accessed and used to help save the person whose heart isn’t pumping.*

*I chair various patient group meetings at most of which we have a guest speaker on a health or care topic. This week Andy Jeynes from West Midlands Ambulance Service (WMAS) presented at one on cardiac arrest, CPR and the use of PADs. He told us that though CEC had provided 68 PADs within the areas that WMAS covers, it hadn’t told WMAS the release code for any of them, despite WMAS having frequently asked it to do so. Thus CEC has bought and fitted 68 PADs for around £1,000 each, which can’t be accessed, so are literally useless.*

*Andy said one person has already died when their life would probably have been saved if WMAS had had the release code for the nearby PAD. I didn’t ask him for details of the case but could obtain them if necessary. The risk of more people having avoidable deaths for the same reason will continue until CEC gives the list of release codes to WMAS. The difficult bit already done was to pay for the PADs and their installation: the last necessary, easy bit is to disclose the codes to WMAS, which needs to be done quickly.*

*CEC could, if it had given WMAS the codes or does so quickly, get positive publicity as a life-saver, but instead it looks culpable: it hasn’t provided the codes as it should have done automatically because of morality and common sense; has ignored multiple requests from WMAS; ignored the phone call that one of your employees based near my home made to ask your head office to release the codes; and so far hasn’t given me any promise that the task will be completed despite my sending a request via your website’s CONTACT US link.*

*The media will have a feast if they find this out from a grieving relative (e.g. “Central England Co-op’s negligence and intransigence has killed someone before, now it’s killed my dad/mother, and will kill more in future”) and the media will no doubt seek a quote from you, as the man responsible.*

*For the benefit of anyone whose heart rhythm is lost near any of the 68 CADs and for the benefit of your own organisation, please issue the necessary instruction to whichever of your staff is responsible for the codes and then make sure the task is completed quickly and fully, then let me know. After that, I’ll double-check with Andy that the codes have been received and entered onto WMAS databank.*

*My email address (preferred method of contact) is xxxxxxxxxxx so I look forward to hearing from you.*

*Best wishes,*

*Tony Green*

Andy said CPR should keep the heart in a state that makes it shockable. If only one person is around when there’s a casualty with cardiac arrest, they can’t simultaneously do CPR and also get a debrillator: of the two, defibrillation is more urgent and important. Once a PAD cabinet is opened it is easy to take out and use the defibrillator. Set it beside the casualty and cut away their clothing because the Pad pads have to be applied to bare, dry skin, on the positions shown on the pad packets – one on the upper right torso and one on the lower left torso. Make sure that the pads are touching only the casualty, not you or anyone else. The PAD will display and tell you what it’s doing, and will shock automatically when it senses a shock will be effective.

If the shock restarts the heart, the casualty’s health will still be frail, so, leaving the pads on, turn the casualty into the classic recovery position, until the ambulance arrives. The paramedic will then inject the casualty with drugs that minimise the risk of them having another heart attack and/or cardiac arrest, then will take them to hospital.

At 7.50 pm the Chair invited **questions for Andy**:

**Q1** What if the casualty is wearing a medicinal patch where the pad should be placed?

**A1** Remove and reposition the patch so that the pad is in direct contact with bare dry skin.

**Q2** What if the casualty’s skin is wet?

**A2** In the PAD there’s a towel that you can use to dry the casuality’s skin.

**Q3** How long after a cardiac arrest would a casualty live if nothing is done to help them?

**A3** After 7-8 minutes of fibrillating the heart goes into faint defibrillation then becomes asystole, which means it’s no longer shockable. Death would occur soon after. This sequence would be slower if the casualty is very fit.

**Q4** What if a child has a cardiac arrest – wouldn’t full force CPR kill them?

**A4** The key aim is the compress the chest by a third of its depth. If that can be achieved for a young child by just using two thumbs then that’s fine: for a newborn baby one thumb may be enough.

**Q5** If the child is say 8, their torso is small, so what if there’s too little room to fit the defibrillator pads in the correct positions?

**A5** If the child is 8 or under, place one pad on their centre front and one on their centre back.

**Q6** Has “tachycardia” got anything to do with cardiac arrest?

**A6** No. “Tachycardia” means the heart is pumping too fast, which might have applied to the heart attack that led to the cardiac arrest, but not after the heart has lost its normal rhythm.

At 8.10 the Chair thanked Andy for his great presentation and all members applauded Andy to show their appreciation. *Note: a copy of Andy’s presentation slides will be sent in early May to everyone on the PPG’s email list.*

Then the Chair invited members to raise matters for general discussion, and/or to ask questions of Rachel, or of any members of the PPG’s steering group. He asked all steering group members present to stand up so others could see who they are and where they are sitting.

One member said he had had to wait two weeks to get an appointment with their doctor. Rachel said the surgery allows appointments to be booked up to two weeks ahead, and each week day they make another day two weeks away available for appointments: when they used to allow appointments to be booked four weeks in advance, patients usually had to wait four weeks.

Another member said he was concerned about a notice that his medical data would be shared by people away from the surgery such as hospitals and maybe dental practices unless he opted out. He didn’t trust everyone who would have access to his records. Rachel said blue leaflets had been sent to all patient addresses by NHS England about the plan to save lives by making sure that basic key data like allergies would be shared between GP surgeries and hospitals. Some other members said they were happy for their health data to be shared if doing so helps to keep them alive and well. The Chair said he will look into the plan and he or someone will report back to a future PPG meeting.

One member proposed that we should all show our appreciation for Rachel for her valuable inputs to the PPG meetings. All members applauded Rachel.

There were no further questions so the Chair thanked everyone, wished everyone a safe journey home and a happy Easter break, and closed the meeting at about 8.20 pm.

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