Buckinghamshire, Hampshire and Oxfordshire Health Overview and Scrutiny Joint Review Group

South Central Ambulance Service: Review of Rural Performance

February 2010

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South Central Ambulance Service: Review of Rural Performance

Introduction

Disquiet about ambulance rural response times has been expressed independently by Health Overview and Scrutiny Committees (HOSCs) in the South Central Strategic Health Authority (SCSHA) area on a number of occasions. As a consequence all HOSCs in the South Central area were invited to confirm if this was an issue that merited further in-depth review. Three HOSCs, Buckinghamshire, Hampshire and Oxfordshire considered that this was an issue of significant local concern and as such should be subject to formal local government scrutiny. A Joint Review Group was subsequently appointed to scrutinise ambulance response times in greater depth.

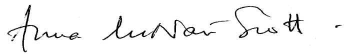
The focus of this review is primarily on the reasons for the considerable variation in response times between emergency ambulance Category A (immediate life threatening) calls in urban areas and rural areas. The review sought to identify what plans South Central Ambulance Service (SCAS) has for additional work and innovation to improve performance, particularly in relation to people living in rural areas.

The issue of ambulance response times is not a new one for HOSCs in the South Central SHA area, or nationally. HOSCs across the region regularly receive an information pack from SCAS that sets out how the Trust is performing against the Category A, B and C standards regionally and across their PCT area(s).

The timescales for completing this work have by necessity been tight and members of the Joint Review Group are acutely aware that the provision of ambulance services is a highly complex area with many interdependencies within the health care and other systems, such as road infrastructure.

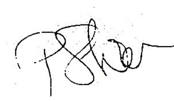
The conclusions and recommendations of the Joint Review Group are drawn from the evidence received, both written and verbal. Some of this material is appended to this report, the rest can be accessed through the links included at Appendix Six or via the web site http://www3.hants.gov.uk/ambulance-services . It is accepted that others reading this material may interpret it differently. The Joint Review Group is however firmly of the view that the recommendations for action, both nationally and locally, will make a significant contribution to improving the performance of the ambulance service.

Grateful thanks must be extended to those that contributed to this work, including the members of the public who submitted evidence to the Joint Review Group. The dedication, passion and commitment of all are real assets that need to be harnessed to meet the challenges that all public sector services are facing. Nationally and locally ambulance services are a vital component of the NHS that is, quite rightly, highly valued by the public. Members of the Joint Review Group look forward to working with all stakeholders to ensure that ambulance services are best placed to meet the needs of people living in the South Central area.



Cllr Anna McNair Scott
HOSC Chairman
Hampshire County Council

Cllr Mike Appleyard
Buckinghamshire Public Health Overview and Scrutiny Committee



Cllr Peter Skolar
Chairman, Oxfordshire Joint Health Overview and Scrutiny Committee

Methodology

The Joint Review Group was established to include representatives of the HOSCs of Buckinghamshire, Oxfordshire and Hampshire as well as co-opted Non-Executive Director (NED) representatives from both Buckinghamshire and Hampshire Primary Care Trusts (PCTs) and a representative from the Local Involvement Network (LINk) in Oxfordshire.

Members of the Review Group were:

Buckinghamshire
Cllr Mike Appleyard
Cllr Paul Rogerson
Mike Williamson (PCT NED)

Hampshire
Cllr Anna McNair Scott (Joint Review Group Vice Chairman)
Cllr Pat West
Cllr Phryn Dickens (substitute)
Susanne Hasselmann (PCT NED)

Oxfordshire
Cllr Peter Skolar (Joint Review Group Chairman)
Cllr Richard Langridge
Anita Highman (Oxfordshire LINk)

The evidence gathering in public took place in two select committee style meetings; these were held on the following dates:

- 27 November 2009 -- County Hall, Oxford
- 3 December 2009 – The Castle, Winchester

The notes from these meeting are attached at appendices Four and Five respectively.

Prior to the evidence gathering days, meetings were held with the SCAS management, PCT commissioners and the Specialist Commissioning Group (SCG). This helped to shape the scope of the review, to inform key stakeholders of the purpose of the review and to gather initial evidence to inform the final report.

Conclusions

National Standards

1. The Joint Review Group came to the view that there is a 'two-tier' ambulance service across rural and urban areas that is caused primarily by the way that the SCAS responds to the nationally determined standards for response times and the way that they are monitored and reported.

2. The standards for responding to calls are set out in a national contract that is not open to negotiation. All Ambulance Trusts across England are expected to deliver the following national standards:

   - **Category 'A'** Life threatening emergency. An emergency response should reach the patient within 8 minutes on 75% of all occasions and a transport capable response should arrive within 19 minutes of it being requested for 95% of all occasions;

   - **Category 'B'** Serious but not immediately life threatening. An appropriate response should reach the patient within 19 minutes on 95% of all occasions;

3. Category A and B standards are measured at a regional level and are designed to enable ambulance services to prioritise resources appropriately across an area.

4. All Ambulance Trust performance is assessed as an aggregated percentage of calls across the area covered by the Trust. The only measure is whether they meet or miss the standards. There are no complementary measures of the quality of service provided or the outcome for the patient. More importantly for the purposes of this review this nationally determined method of reporting performance means that information about local variations in response times is not routinely reported or assessed.

5. Data provided to the Joint Review Group clearly demonstrates that performance in high call volume (generally urban) areas is better than that in low volume (generally rural) areas (see Appendix One page 2 for a breakdown of the classification). Figures produced by South Central Ambulance Service (SCAS) show that rural performance can fall to less than 30% in some areas, averaging less than 50% across Oxfordshire, Buckinghamshire and Hampshire in August 2009- October 2009 (see Appendices Two and Three). The outcomes for patients as a result of this variation in performance are not clear. No other metrics are routinely applied through contracts to assess the performance of ambulance services although the Care Quality Commission (CQC) does look at some other indicators of clinical quality such as delivery of thrombolysis. There was reference in evidence provided to the Joint Review Group to other quality indicators that are being developed by SCAS and commissioners.

6. The Joint Review Group is convinced that there are some major failings in relation to the measurement of national targets. There is no 'floor' in terms of maximum response times: a standard is either achieved or missed. When questioned on this point SCAS said they did capture this information but did not consider it appropriate to look at the range of response times and adjust the deployment protocol to reduce the 'tail' of response times that do not hit the standard.

7. The attendance of 'indirect support' at an incident in the form of community or co-responders 'stops the clock' with regard to Category A response times (see Appendix One for a more detailed explanation of 'indirect support' and the work of community and co-responders). 'Running calls' (i.e. incidents dealt with by an ambulance crew when they are on the road or at an event), are included in Category A response times, even if they are not life threatening emergencies.

8. The Joint Review Group is of the view that this emphasis on fixed standard response times, regardless of other factors such as vehicle travel times or patient outcome, is having a perverse impact on performance. The aggregation of standards to give an overall 'pass or fail' rating encourages Ambulance Trusts to concentrate on achieving high response time performance in urban areas and masks underperformance in rural areas. Consequently significant variations in performance are not routinely captured in the measurement and reporting of performance. This aggregation of data and the lack of focus on patient outcomes mean that there is no incentive to address performance issues in rural areas or adjust the deployment model to prevent resources being drawn by default into areas of high demand.

9. This is a national issue that needs to be addressed urgently by the Secretary of State for Health.

Commissioning Arrangements

10. The Joint Review Group is of the view that commissioning arrangements are weak and confused. Performance management is attempting to get to grips with the issues but this has only begun to move forward in the last few months. The role of Primary Care Trusts (PCTs) versus the Specialist Commissioning Group (SCG) is not clear particularly with regard to the levers for change and governance arrangements.

11. Quality measures are in the process of being defined and have the potential to inform next year's contract. The Joint Review Group would strongly endorse and support this work.

12. PCTs do not routinely look at rural performance. Their insistence that there is not a 'two tier' service across urban/rural areas was not supported by the evidence provided to the Joint Review Group.

13. The terms 'standard' and 'target' were used interchangeably by SCAS and commissioners: one is a minimum that needs to be delivered, the other, an aspiration to be achieved.

14. The Joint Review Group feel that there needs to be clarification of the role for the South Central Strategic Health Authority (SCSHA) in overseeing the performance of SCAS and the effectiveness of PCT commissioning.

15. The Joint Review Group is of the view that accountability needs to be better defined as different stakeholders manage different elements of the commissioning process, sometimes the PCTs take the lead directly, at other times the SCG takes the lead. At present the SCG does not appear to have the commissioning 'clout' to hold SCAS to account for performance in individual PCT areas. It is not possible to differentiate between those performance issues that are unavoidable and those where improvements can be made, nor what incentives and penalties are being employed and if these are effective.

16. There is broad consensus across SCAS, PCTs and the SCG that the ‘Atos’ Report, jointly commissioned by the SCSHA, the PCTs from across the South Central region and SCAS in 2008, formed the basis of the contract with SCAS. Crucially ‘Atos’ was intended to resolve disputed performance and cost issues between SCAS and commissioners, providing an agreed basis for moving forward in the future. The two year programme that resulted from the 'Atos' Report included additional funding from PCTs for a 2 year period (due to expire in July 2010), when funding will revert to previous levels. During this period SCAS was expected to complete a programme of work (‘Towards Excellence’) that would enable costs to be reduced and performance improvements delivered and sustained beyond the end of the programme. Despite this agreement SCAS provided reports to the Joint Review Group that suggest there is still a shortfall in funding necessary to reach the national standards. The figures provided by SCAS to the Joint Review Group are strongly disputed by the commissioners.

17. The Joint Review Group is of the view that the continued dispute between SCAS and commissioners about the resource required to achieve national standards is extremely unhelpful, particularly given the financial pressures that are building in the NHS. The issues have to be resolved once and for all if performance in rural areas is to be improved and sustained. Furthermore the lack of basic information about the level of service actually funded by PCTs is of significant concern to the Joint Review Group and needs to be addressed as a matter of urgency.

18. Evidence provided to the Joint Review Group about the extent to which the recommendations from the ‘Atos’ Report have been adopted and the associated programme of improvements delivered is contradictory. There were different interpretations of a number of areas included in the 'Atos' report some of which are fundamental in terms of contracting, for example:

    - Whether the service delivery model developed by Lightfoot Solutions as part of the ‘Atos’ review, which sets differential performance standards across urban, semi urban and rural settings (defined by number of calls, not population density) has been agreed with commissioners.
    - Whether Category B calls are funded.

19. The frustrations expressed by all witnesses suggest that little has moved on since ‘Atos’ and the dispute over performance and finance has not been resolved.

20. There is some indication of an overall improvement in performance by SCAS which must be acknowledged. Both SCAS and commissioners provided copious data and information but it was not possible for the Joint Review Group to ascertain what improvements had actually been delivered in terms of rural performance. The focus on achieving the national standards appears to have had the consequence of drawing resources away from rural populations and into urban areas. The case put forward from SCAS to support this position was the need to deploy resources to the areas of greatest priority; however other witnesses suggested that this approach enables overall performance targets to be met more easily. The consequence of this model is that people in rural areas experience longer waits for attendance by a clinically qualified practitioner as the community responders or co-responders who may reach the incident first (and therefore 'stop the clock') can only provide basic first aid, defibrillation if required and reassurance.

21. The contradictory information about the adoption of the 'Lightfoot' model proposed by 'Atos', which sets differential targets for urban, semi urban and rural areas (defined by call rate) is a significant issue to be addressed. Members of the Joint Review Group were clear that they did not support differential targets.

22. The year on year increase in calls reported by SCAS was not complemented by any indication of work in hand to either identify the reasons for this increase or establish alternative care pathways that work across the unscheduled/urgent care system. There was some evidence of initiatives to address blockages in the system (e.g. ambulance turnaround times at hospital A&E Departments) and identify alternative care pathways (e.g. to prevent the need to convey a patient) but it was not clear if this extended to all localities or what improvements had been realised as a result of this work. There was no evidence that the benefits to be gained from the operational improvements envisaged by 'Atos' were at a point where they could be rolled out across SCAS or even within divisions.

23. The Joint Review Group is of the view that the pressure points identified within the system are the same as those reported in 2008. The operational issues identified by 'Atos' continue to have a direct impact on the performance that SCAS is able to achieve. Notable successes, such as the Hampshire co-responder scheme, seem isolated. Pilot work to improve turnaround at A&E has yet to be assessed and is some way from being rolled out to other acute trusts although these pressures are continuing to build. This is a system wide issue that requires a system wide solution. SCAS quite correctly acknowledges that it cannot take forward this work in isolation however it was not clear what action is being taken by SCAS to address these issues.

24. Relationships between SCAS and their key stakeholders - especially commissioners - are poor. Lines of accountability and responsibility are confused. Significant data is produced but it is not customised to different stakeholder requirements, neither is it user friendly or easy to interpret. This is a significant weakness that needs to be addressed.

Deployment of Resources

Trained Staff

25. The Joint Review Group is concerned that the shortfall in operational capacity identified in 'Atos', particularly in relation to Category A calls, remains. There were reports of a shortage of qualified staff which should have been corrected as part of the 'Atos' recommendations.

26. For example, the Joint Review Group received conflicting information about the use of Emergency Care Assistants (ECAs) particularly in terms of two ECAs deployed in a Double Crewed Vehicle (DCV). SCAS stated at the 3 December Select Committee that ECAs in an ambulance were only used for non emergency patient transport. The SCAS Risk register (Oct 2009) however notes that there are instances where DCVs crewed by two ECAs are being sent to emergency calls and refers to a directive 'identifying circumstances when it is permissible to mobilise a double ECA crew to emergency calls'. Reference is made to high levels of ECAs but not to action being taken to ensure that these staff only work with a qualified clinician (either a technician or a paramedic). Staff representatives expressed a view that this practice represents a significant risk and there was deep concern that this was sanctioned by SCAS.

27. It was not clear how the most experienced staff are deployed to make maximum use of their skills and some staff expressed considerable frustration about the way in which their skills are used. There were reports for example of qualified Emergency Care Practitioners (ECPs) being deployed in single manned Rapid Response Vehicles (RRVs) and going through an entire shift without being called.

28. Although SCAS reported improvements in rural response times it was not possible to determine how much of this is attributable to improvements in SCAS' internal efficiencies or the use of first responders (whether community or co-responders) or what proportion is made up of 'running calls'.

Community and Co Responders

29. The Joint Review Group acknowledges the important contribution that community and co-responders make to supporting patients in response to emergency calls. This is a complement and not an alternative to an ambulance, but by arriving on the scene the community and co-responders ‘stop the clock’ in terms of the recorded response times. The extent to which this gives a misleading indication of ambulance response times is not clear. In Hampshire’s mainly rural areas for example there is a significant co-responder scheme that is able to respond to Category A calls in 8 mins in 77% of cases. However if the performance figures for rural areas in Hampshire provided by SCAS are examined by rural/ urban split there is a downward trend (see Appendix Two). It is not clear if this indicates that the actual response times of SCAS to Category A calls are worse than reported, despite the support of co-responders.

30. SCAS stated that a vehicle is deployed to a Category A call before a community/co responder is deployed and this was confirmed by the responders who gave evidence at the Select Committees. There were other reports that this may not always be the case.

31. In rural areas responders familiar with the geography of their communities are able to ‘sign-post’ a vehicle. This can be a considerable help in enabling a deployed vehicle to get to an incident as quickly as possible.

32. Community and co-responders are clear about their limits but could do more particularly in relation to falls and initiating some basic clinical tests (e.g. blood sugars). SCAS highlights falls as a key issue in terms of taking up ambulance time so there would be merit in exploring if the responders could do more in this area although this may have implications in terms of clinical governance.

33. The co-responder scheme in Hampshire is an exemplar and should be rolled out in other areas.

34. The community responder schemes enable help and reassurance to be with patients as quickly as possible particularly in rural areas where ambulance travel times are inevitably longer.

35. The Rural Strategy document sent to the Joint Review Group by SCAS gives a helpful description of the role played by community/first responders. This needs to be developed and communicated to ensure that there is greater clarity amongst SCAS staff and the public about the role of this valuable resource.

36. The Joint Review Group do not consider it appropriate that, as a complementary service to ambulances, attendance at an incident by the responders should 'stop the clock'. More information is required about the availability of vehicle back up and the appropriateness of this.

Staff Support and Training

37. The Joint Review Group noted that community and co-responders are retrained every 6 months but ambulance staff do not seem to have a similar scheduled programme for retraining and up-dating skills. However clinical development up-date training is now planned.

38. The evidence provided by staff representatives raised a number of concerns and the Joint Review Group is of the view that more could be done to improve morale and cross-organisation working. Feedback from staff suggests they can feel isolated and remote from management although it was noted that staff appraisals are in the process of being introduced and that this should help reduce the isolation.

39. There appear to be issues relating to training and its effectiveness as well as the way in which staff are able to access career pathways and continue to build their skills. One of the projects taken forward as part of the 'Atos' review was 'to provide a new approach to paramedic training to give an alternative to university qualification'. It is not clear if this has not been taken forward because of changes in national requirements but if the route to becoming qualified as a paramedic is only via a degree this imposes constraints on the numbers that can be trained at any one time.

40. It is not clear how the training needs of paramedics and technicians are identified and met. The Joint Review Group would find it helpful to have confirmation of the training provided for staff and the opportunities for developing the skills set of experienced staff to enable them to keep abreast of clinical practice and develop further.

41. SCAS has stated that it is short of paramedics, particularly in Hampshire but it is not clear what is being done to address the shortage. A number of commentators highlighted the benefits of the knowledge that experienced staff build over years. It was not possible to ascertain the extent to which staff are encouraged to 'move through the ranks' in order to capitalise on and develop this experience. It was reported that training programmes had been under pressure in recent years. Emphasis seems to have been placed on ECAs to the detriment of other staff grades.

Call Management

42. A number of concerns were expressed about the Computer Aided Dispatch (CAD) system and the way in which triage is conducted, particularly the speed with which it has to be completed in order to determine the need to dispatch a vehicle. The Joint Review Group is of the view that an alternative system, such as NHS Pathways, used by some other Ambulance services, may be more flexible than the current system used by SCAS.

43. It was not clear how the CAD system matches up the most appropriately skilled staff/standby units with the most relevant call. Some evidence suggests that it is the nearest rather than the most appropriate resource that is deployed. In some instances this may result in multiple resources attending a call.

44. The need for local knowledge of an area was stressed by several commentators but it was not possible to determine how this is captured to ensure that the CAD and Satellite Navigation systems are able to ensure effective routing to incidents or accommodate changes in the road infrastructure. The Joint Review Group felt it would be beneficial to have confirmation about how and when these systems are updated to ensure that vehicles are directed appropriately. The 'Atos' report highlighted this as an issue and pointed out the gazetteer being used at that time was out of date.

45. Cross border protocols are not in place that enable vehicles from other Trusts (or indeed Divisions) which may be closer to an incident, to be deployed. This is, at least in part, attributable to control centres being unable to share information about the deployment of resources. The Joint Review Group feel that this is an issue that needs to be addressed as quickly as possible.

46. Different views were expressed about how some conditions, such as stroke, are categorised in terms of call urgency.

47. Opportunities to access support through other resources and alternative care pathways in rural areas (e.g. the Out of Hours service) have yet to be explored systematically.

48. Schemes using GPs and nurses to triage calls – Clinical Support Desks - are in place. 'Atos' suggests that this should be in place across SCAS on a 24/7 basis. The extent to which this has been achieved needs to be confirmed.

Rural performance

49. There was evidence that vehicles and staff are deployed across areas at the start of a shift but as calls come in resources are allowed to be drawn into high volume call areas - particularly around A&E Departments - and then not replaced in rural areas.

50. The paper provided by SCAS about improving rural performance gives no indication of how the issues relating to low call density would be addressed beyond the introduction of more community/co-responders, although the reference to the need for cross system working to address bottle necks is helpful.

51. The Joint Review Group is of the view that currently the over-servicing of urban areas is to the detriment of the rural areas.

Summary

52. The only consistent point of agreement across stakeholders was the adverse impact on performance of the national standards and the need for more sophisticated indicators of quality and outcomes for patients. The Joint Review Group agrees that performance cannot simply be measured by the achievement of a specific response time: the lack of meaningful metrics to demonstrate the quality of care and service is a major failing. The inflexibility of the national contract, the commissioning by 'committee' and the resulting lack of leverage that commissioners have to address performance issues are a source of significant concern. The Joint Review Group considers that meaningful outcome measures need to be developed to sit alongside any evaluation of ambulance service performance. Some measures, such as cardiac survival rates, do exist and are in use elsewhere in the country. These need to be used more extensively by service providers and commissioners as a means of understanding performance and quality of care.

53. It was not possible for the Joint Review Group to determine the extent to which the performance and funding issues identified in 'Atos' have been addressed. SCAS maintains that, in order to improve performance, additional funding is required: commissioners are equally adamant that the improvements have already been agreed within the current contract. The Joint Review Group was not able to establish the true position in the time available.

54. There are strongly held and opposing views about the nature and content of the contract, the need to achieve national standards and the performance of SCAS. Commissioners say they do not commission a 'two tier' service and SCAS says it does not provide one- despite the fact this is clearly what is actually being delivered to the population.

55. The Joint Review Group is of the view that, in the 18 months or so since the 'Atos' report, little has changed from the circumstances that prompted this review. There is a real risk that the coming year will see both performance and finance disputed yet again, repeating a cycle that frustrates all.

56. The Joint Review Group is firmly of the view that:

- The current emphasis on the delivery of the national response times is contributing significantly to the creation of a ‘two tier’ ambulance service that disadvantages people living in rural areas

- There are relationship management issues within SCAS and with commissioners, and some operational shortcomings which contribute to the delivery of this ‘two tier’ service.

- Current performance monitoring arrangements take no account of patient outcomes

- Commissioning is weak and confused.

Recommendations

A detailed plan is required to address the current inequity between urban and rural performance. This plan requires sign up and long term commitment from South Central Ambulance Service, South Central Strategic Health Authority and PCT commissioners. Immediate action is also required by the Secretary of State to review the national contract.

The following recommendations outline the key areas that will impact on improvements to service provision.

1. **Local Commissioning**

Commissioners, working with SCAS should agree a detailed action plan, including timelines and designated responsible officers, to free resources and improve the response times of the ambulance service in rural areas. This should include programmes to address all segments of major demand and shall include the following:

- clinical quality and patient outcome indicators as well as risk assessment at the point of call triage to be included in the contract for 2010/11. This should include quality outcomes measures around cardiac care, long term conditions, falls, mental health and stroke and an analysis of patterns and trends in Serious Untoward Incidents (SUIs) and complaints.
- Management of requests for ‘urgent’ transport from GPs
- Support for people who have mental health problems or make inappropriate calls
- Identification and management of people who have falls
- Conveyance and Do Not Resuscitate (DNR) protocols for those people who are at the end of life
- Frequent users of emergency services
- Deployment of vehicles so as to ensure that urban areas are not ‘over performing’ to the detriment of rural responses.
- Commissioning of all elements of the patient pathway and not just the arrival at the scene of an incident. This shall include:
    - consideration of alternative call handling models to help ensure resources are deployed according to need
    - the development of alternative care pathways to ensure that patients are not taken to hospital A&E unnecessarily
    - reduction of ambulance turnaround times at acute hospitals.

Progress and timelines for completing this work to be reported to the Joint Review Group by **31 March 2010.**

2. **National Performance Standards**

An urgent review of the national standards and the contract is commissioned by the Secretary of State to ensure that Ambulance Trust performance reporting reflects the entire patient pathway – not simply arrival at the scene of an incident.

As part of this review consideration should be given to:

- Reporting response times separately for urban, semi-urban and rural areas (according to population density) to enable direct comparisons to be made.
- Identification of quality and patient outcome metrics based on clearly defined care pathways to complement response times and enable direct comparison of outcomes between urban, semi-urban and rural areas.
- Risk assessment at the point of call triage being built into performance outcomes
- An agreed maximum waiting time for responding to different call categories. All calls that exceed this 'floor' to be routinely monitored and published.
- An agreed national approach to unscheduled/urgent/emergency care pathways that is able to ensure that resources are deployed across urban, semi-urban and rural areas as effectively as possible. This should include the role, responsibilities and accountability of first responders.
- Excluding 'running calls' as part of the evaluation of Category A performance
- Community/co responders not 'stopping the clock' for ambulance response times

A response that identifies clearly what the Secretary of State intends to do and by when will be provided to the Joint Review Group by the **31 March 2010.**

3. **Governance and Accountability**

- The SCSHA and SCPCTs commission urgently an independent, appropriately qualified evaluation of the delivery of the recommendations from the 'Atos' Review and the 'Towards Excellence' programme.

- Individual PCT Boards should publish governance arrangements supporting the commissioning and performance management of services provided by SCAS. This will include:

- Identification of a Non-Executive Director (NED) to track and challenge SCAS performance
- The role and responsibilities of the Specialist Commissioning Group (SCG)
- Locally specific performance and outcome information and demand mapping.

Progress with this work will be provided to the Joint Review Group by **31 March 2010.**

4. **Building Ambulance Service Capacity**

SCAS will:

- provide clear and concise information about the role, responsibility and contribution of community and co-responders to improving patient outcomes

- identify those localities that will benefit most from the introduction of Community Responder and Co-Responders and invite local councillors in their role as 'community leaders' to promote and help publicise these schemes

- develop protocols to enable cross division and cross border communication and support.

Progress with this work will be reported to the Joint Review Group by **31 May 2010**.

5. **Evaluating Progress**

Progress against these recommendations will be assessed by the Joint Review Group **12 months** after the publication of this report.

Glossary of Terms

CAD	Computer Aided Dispatch
Conveyance	The conveyance of patients, medical and clinical personnel, equipment and associated records, as appropriate including from one healthcare facility to another as well as the initial journey from the scene.
DCV	Double Crewed Vehicle
Drive Zone	Designated geographical area inside which an ambulance vehicle can be placed on stand-by and respond to an incident inside the relevant drive zone within a specific period of time to meet national performance targets.
ECA	Emergency Care Assistant
ECP	Emergency Care Practitioner
Handover	A handover occurs when ambulance crews arrive at a hospital emergency department and transfers the care of the patient to hospital staff.
HOSC	Health Overview and Scrutiny Committee
LINk	Local Involvement Network
NED	Non Executive Director
PCT	Primary Care Trust
SCAS/T	South Central Ambulance Service/Trust
SCG	Specialist Commissioning Group
SCSHA	South Central Strategic Health Authority
RRV	Rapid Response Vehicle