THE AMBULANCE SERVICE IN BASSETLAW

February 2013

BASSETLAW
DISTRICT COUNCIL
NORTH NOTTINGHAMSHIRE

www.bassetlaw.gov.uk

Foreword

This report is in response to local concerns about the Ambulance Service in Bassetlaw. The local community were greatly concerned to learn of proposals to close the Ambulance Stations in the district and replace them with a Hub at Kings Mill Hospital, Mansfield. Therefore, this review was not only timely but necessary to ensure the views of the district were heard.

Throughout the review we have gathered evidence from a wide range of people and sources. The Panel respect the work of this valuable service both staff and volunteers that save lives in Bassetlaw. However, the evidence shows that rural areas like Bassetlaw have poorer response times than urban areas and that the proposals favour urban areas. The review has put forward a strong case to retain our Ambulance Stations and for improved services in the district.

There was cross party unanimity that we had no confidence in the proposed changes and believe that resources need to stay within the district. There was great deal of community support and these were included in the Health Panel's response to the consultation. The Health Panel again unanimously urged EMAS to reconsider their proposals and listen to what local people have said.

It soon became evident that the vast majority of consultees believe Retford and Worksop Ambulance Stations should remain in situ and be enhanced where necessary. The Panel also made recommendations for more investment in the Community First Responders who volunteer their time to help those in need and for better engagement between EMAS and the public.

I would like to thank all of the people that have contributed to this review, particularly the EMAS staff, patients, commissioners and other health providers, your time and information was much appreciated.

Councillor G. Oxby
Chair of Health Panel

February 2013

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1. Executive Summary

1.1 Summary of Findings

Bassetlaw District Council's Health Panel was tasked to review The Ambulance Service in Bassetlaw as part of the Annual Work Programme 2012/13. The topic was approved by Overview and Scrutiny Committee in June 2012.

The review addresses the ambitions of the Corporate Plan 2012-2015 as follows:

AMBITION 3: INVOLVED COMMUNITIES AND LOCALITY WORKING
Priority 4 – Work in partnership in support of local services.

This review arose following concerns about the level of service provided by the East Midlands Ambulance Service in Bassetlaw. This was further compounded by proposals to introduce a new model of service which included closing all 66 ambulance stations in the East Midlands and replacing them with Community Ambulance Points (CAP). This would mean the closure of the two ambulance stations in Bassetlaw and the relocation of staff to Kings Mill Hospital in Mansfield, where the Hub serving the Bassetlaw area would be situated. The Committee approved the scope and terms of reference (see 1.2). The Panel carried out two one-day meetings to gather evidence from a wide range of employees, patients, Community First Responders and other healthcare providers. The Panel also worked with East Midlands Ambulance Service, Bassetlaw Clinical Commissioning Group and other ambulance services in England.

The review focused on the emergency provision for the district, this included how the service was commissioned and how the service currently operated. The review also looked at the quality and performance of the service provided including response times. EMAS has failed to meet national standards for A8 (eight minute response to serious and life threatening calls) and A19 (19 minute response for a vehicle able to transport serious and life threatening calls) calls for the last three years. This has resulted in £5 million of penalties being exacted on EMAS. The Panel also compared the district's response times with the county and regional performances and saw that response times in the district were much poorer.

The review highlighted the issue of turnaround times at hospitals as these also impact on response times. Bassetlaw Hospital was found to be failing these targets. EMAS has subsequently decided to apply penalties on hospitals that fail the targets. This issue has also been brought further into the spotlight with the publication 'Zero Tolerance – Making ambulance handover delays a thing of the past' report from NHS Confederation.

The improvement of these response times were reported to be at the heart of the proposals of the EMAS 'Being the Best' consultation. Therefore the review looked at the proposals and the likely impact on the district's service provision. The Panel found there were concerns that the new model would benefit urban areas and did not take into account the needs of a rural district. The distance of the Hub at Kings Mill Hospital would have serious implications for the district and the EMAS staff.

The Health Panel's key findings are:

1 The proposed changes to how the Ambulance Service is delivered in Bassetlaw will not benefit Bassetlaw residents.
2 That Bassetlaw needs to keep its ambulance vehicles and staff within the district.
3 The current ambulance service is designed to meet national response times, rather than patient outcomes.
4 Response times in Bassetlaw are significantly lower than urban areas and therefore affect outcomes.
5 The current national commissioning arrangements do not suit rural areas such as Bassetlaw.
6 Turnaround times at Bassetlaw Hospital need to be improved, as this impacts on the Ambulance Service's ability to deliver an efficient service.
7 Community First Responders are a key part of the Ambulance Service and as such there should be further investment in recruiting new volunteers and retaining existing volunteers.
8 EMAS' consultation process relied too highly on its website.
9 Improvements to public engagement by EMAS are necessary.

As a result of the evidence gathered during the review, members have agreed five key recommendations as detailed further at 1.4 and in section 4 of this report:

- **That EMAS should reconsider the proposals set out in their consultation 'Being the Best' with immediate effect.**
- **That the Ambulance Stations in Bassetlaw should remain open.**
- **That Bassetlaw should retain Emergency Ambulance Service resources locally**.
- **That the Clinical Commissioning Group should explore and participate in future changes to commissioning which will better suit Bassetlaw's needs.**
- **That there should be further investment in recruitment and training of Community First Responders, including the provision for travel expenses and a uniform.**

An Equality Impact Assessment has been carried out for this review. This can be viewed at www.bassetlaw.gov.uk under the Equality Section or by contacting the Policy and Scrutiny Unit on 01909 533189.

1.2 Scope of the Review

Our Ambition

To review the Emergency Ambulance Service in Bassetlaw, to ensure that Bassetlaw's future ambulance provision is maintained and improved.

Our Scope/Lines of Questioning	
To review the Emergency Ambulance Service within Bassetlaw	• Current Provision, staff clinicians and vehicles • Current Performance, response times, complaints • The role of Community First Responders
To understand why the Emergency Ambulance Service is not meeting targets	• Possible causes of recent poor performance • What impact does carrying out patient transport for patients using oxygen have on emergency calls
To understand the proposals for changes to the service fully and its impact on Bassetlaw	• Impact of proposed changes on service • To challenge EMAS's assertions that this is the way to improve services • The impact of proposed changes on Community First Responders • The cost of improvements to current ambulance buildings in Bassetlaw
Key outcomes of the review	• Ensure the public are aware of consultation of the Ambulance Service • Promote an improved Ambulance service for Bassetlaw • Provide a robust and evidence based response to the consultation

1.3 Membership

- Councillor G.A.N. Oxby (Chairman)
- Councillor G. Freeman (Vice-Chairman)
- Councillor A. Battey
- Councillor H.M. Brand
- Councillor M. Gregory (as of 10/10/12)
- Councillor B. Hopkinson
- Councillor S. Isard (Mrs)
- Councillor G. Jones
- Councillor A. Mumby
- Councillor C. Palmer (replaced as of 10/10/12 by Councillor Gregory)
- Councillor M.W. Quigley (Mrs)

1.4 Summary of Recommendations

	Recommendation	**Responsible Body**	**Financial Implications**	**Delivery Timescale**	**Risks to Delivery/ Officer Comment**
1.	**That EMAS should reconsider the proposals set out in their consultation 'Being the Best' with immediate effect.**	EMAS	None for BDC	31/01/13	
2.	**That the Ambulance Stations in Bassetlaw should remain open.**	EMAS	None for BDC	31/03/13	
3.	**That Bassetlaw should retain Emergency Ambulance Service resources locally.**	CCG/EMAS	None for BDC	31/03/13	

	Recommendation	Responsible Body	Financial Implications	Delivery Timescale	Risks to Delivery/ Officer Comment
4.	That there should be no cuts in the current service provision. Where EMAS insist that resources need to be cut or re-aligned the Health Panel expect a clear indication as to what alternative arrangements are in place, voluntary or otherwise, to cover the gaps left in resource provision. Any changes in provision should be reported to Bassetlaw District Council's Overview and Scrutiny Committee.	EMAS	None for BDC	ongoing	
5.	That all response times in Bassetlaw should meet the national standards.	EMAS	None for BDC	01/04/14	
6.	**That the Clinical Commissioning Group should explore and participate in future changes to commissioning which will better suit Bassetlaw's needs.**	Bassetlaw CCG	None for BDC	ongoing	The CCG is already progressing this issue.
7.	That the Chair of Overview and Scrutiny should lobby the Department of Health to review the Ambulance Service as a whole in relation to the response times.	BDC	None for BDC	31/07/13	
8.	That EMAS reconsiders its cross-border arrangements with Yorkshire Ambulance Service to ensure there are adequate resources in place	EMAS	None for BDC	01/04/14	

	Recommendation	Responsible Body	Financial Implications	Delivery Timescale	Risks to Delivery/ Officer Comment
9.	That the Commissioners, Primary Care Clinicians and the Hospital work together to ensure that patients are clearly signposted to the appropriate care pathways and reduce the number of non-emergency patients attending the A&E Department.	Doncaster and Bassetlaw Hospitals Foundation Trust Bassetlaw CCG	None for BDC	01/04/14	The CCG is already progressing this issue.
10.	That EMAS continue to work on the post-handover target which is currently not being achieved.	EMAS	None for BDC	01/04/14	
11.	That Bassetlaw Hospital needs to further improve turnaround times and avoid future financial penalties. The progress of turnaround times at Bassetlaw Hospital should be reported to the Annual Health Summit (or OSC).	Doncaster and Bassetlaw Hospitals Foundation Trust	None for BDC	01/04/14	
12.	That EMAS review their consultation process to ensure that it is improved and is not reliant on the Website and that there was a more joined up approach with partners.	EMAS	None for BDC	31/12/13	
13.	That EMAS should review its current protocols regarding the publishing of Board Papers and the submission of questions by the public. The time period should be extended between the publishing of the papers for the Board of Directors Public Meeting and the deadline for submission of questions to five working days.	EMAS	None for BDC	31/05/13	

	Recommendation	Responsible Body	Financial Implications	Delivery Timescale	Risks to Delivery/ Officer Comment
14.	**That there should be further investment in recruitment and training of Community First Responders, including the provision for travel expenses and a uniform.**	EMAS	None for BDC	01/04/14	

2. Background

2.1 Background to East Midlands Ambulance Service

In 2006 Northamptonshire Ambulance Service, Lincolnshire Ambulance Service and East Midlands Ambulance Service merged to form the East Midlands Ambulance Service NHS Trust (EMAS). EMAS provides emergency 999, urgent care services for the 4.8 million people within Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire. They also provide Patient Transport Services in North and North East Lincolnshire.

The Trust dispatches vehicles (454 vehicles) to 592,600 of these calls every year, with some responses requiring on-scene treatment and others requiring conveyance to another healthcare facility. The Trust operates from more than 70 locations across the East Midlands, including two Emergency Operation Centres (EOCs) in Nottingham and Lincoln (which host the Trust's call handling function) and a large number of ambulance stations across the region. Operationally the Trust's frontline services are divided into five divisions: Derbyshire, Leicestershire and Rutland, Lincolnshire, Nottinghamshire and Northamptonshire.

EMAS employs over 2,700 staff at more than 70 locations, including two control rooms at Nottingham and Lincoln. The Trust also recruits volunteers Community First Responders who play a vital role in the delivery services. The number of volunteers working in partnership with EMAS stands at 557. The accident and emergency crews respond to over 776,000 emergency calls every year. These calls are increasing on average by 5% per year.

The service is commissioned jointly with the nine Primary Care Trusts which covers the whole of the East Midlands. The Contract is managed by EMPACT (East Midlands Procurement and Commissioning Transformation) who are procurement specialists on behalf of the Primary Care Trusts and handles all of the bureaucracy. The current contract began 2011/12 and runs for three years. The total cost of the East Midlands contract is £131 million of which £3.52 million is Bassetlaw's share.

2.2 Background to the Ambulance Service in Bassetlaw

Currently the District is serviced by two ambulance stations, in Worksop and Retford. There are 60 staff based in Bassetlaw along with Community First Responders. There is an Operational Support Manager and five Paramedic Team Leaders who cover three stations Newark, Retford and Worksop.

Resources include:

4 x double manned crewed ambulances
1 x fast response vehicle
1 x Emergency Care Practitioner
1 x Paramedic Team Leader car

The majority of emergencies are taken to Bassetlaw Hospital, however patients with strokes and some serious trauma are sent directly to Doncaster Royal Infirmary, also some heart conditions are sent to the Hallamshire Hospital in Sheffield. This means that ambulances go out of the EMAS region.

The Trust achieved the required response targets for the period 2006 to 2009, but the focus was entirely on performance as opposed to quality of care. EMAS failed to achieve national ambulance response targets for the period 2009/10 and 2010/11 for Category A8 and A19 calls.

Ambulance Services are required to meet response time targets on average across the whole area they cover. There is no requirement for them to meet these targets in each locality area individually. Therefore, if EMAS meets the target across the East Midlands as a whole it will be judged as delivering the required standards even if performance is below target in individual counties or districts. In addition, EMAS has also faced significant challenges in meeting clinical quality standards and maintaining a healthy financial balance.

An independent inspection was carried out on all of the ambulance stations using the NHS Estate Code. It reported that the cost to bring the estate up to standard would be in the region of £13 million.

In April EMAS ceased to provide the Patient Transport Service for the majority of the region only retaining the contract in North Lincolnshire. Commissioners chose to place the contract for this service with a private sector organisation – Arriva.

2.3 Background to Bassetlaw – A Rural District

Bassetlaw is situated in North of Nottinghamshire and comes under the Nottinghamshire Division of the East Midlands Ambulance Service. The district is described as predominantly rural by the Rural Services Network, with 63.7% of Bassetlaw being identified as rural by the Rural Services Network.

The 2011 census reports that Bassetlaw has a population of 112,900. The population has a high proportion of older people than the national average. Deprivation is higher than average and about 4,100 children live in poverty. These areas of significant deprivation are in Worksop South East, Retford and Carlton-in-Lindrick. The Health Profile has identified health inequalities in these areas which impact on life expectancy.

Bassetlaw has a number of major roads running through the District. These include the M18, A1 and A57. The M1 is also close by. Retford has a high speed train network, a prison, and a high security hospital. There is also an airport in Gamston and two power stations in the district. There is a lot of agriculture in the district due to the rurality and this sector has been highlighted as one of the highest for fatal/major injuries[1]. All of this generates areas of increased likelihoods of serious incidents which need to be taken into account by EMAS when determining service provision for the area.

The response times in Bassetlaw have been consistently lower than the national target. The national target for A8 call is 75% and A19 calls is 95%. The deterioration has been noted by the Clinical Commissioning Group separately to this review and they have subsequently increased the monitoring of response times to weekly rather than monthly and have begun discussions with EMAS about improving the response times and more importantly reporting patient outcomes and experience.

[1] Health and Safety Executive

3. Method of Review

3.1 Summary of Review Meetings

Meeting	Witnesses	Evidence Gathered
12th September 2012 6 pm – 8 pm	Janette Turner – Research Fellow Medical Care Research Unit Sheffield University	Background information about Ambulance services
27th September 2012 10 am – 4 pm	EMAS employees Mr Gavin Briers – St. Johns Ambulance Community First Responder (Retford) Alan Sutton – LINk Mark Ward – Trade Union Rep (Local) Emma Bardney – Trade Union Denise Strydom – Patient Representative (Larwood Practice) *Michael Walker – Patient Representative (North Leverton Practice) Jeff Hind – Patient Representative (Larwood Practice)	Ambulance Service employees roles and how the current system works. Concerns about the proposals Patient groups views.
19th October 2012 10 am – 4 pm	Phil Mettam – NHS Bassetlaw/CCG Local Commissioner Sue Wood – Doncaster & Bassetlaw Hospital Foundation Trust Sally Clark – Newgate Medical Group Alan Baranowski – Locality Director A&E Operation in South Yorkshire (Yorkshire Ambulance Service) Annie Berry – GMB Paul Brown – Unison Emma Bardney – Unison Phil Milligan – Chief Executive of EMAS Richard Henderson – Assistant Director of Operations (EMAS)	Commissioning of the Ambulance Service Turnaround times GP Practices' experiences Cross border agreements with Yorkshire Ambulance Service Regional Union views regarding the proposals Presentation of the proposals

Meeting	Witnesses	Evidence Gathered
13th November 6.30 – 8.30 pm	Joelle Davis – Major Projects Officer, Planning	Planning developments for the district

* Witness provided written information

3.2 Surveys

3.2.1 Survey of Local Authorities in the East Midlands Region

At the beginning of the review the Panel thought it would be prudent to find out if other local authorities were scrutinising the Ambulance Service and how they were responding to the proposed changes to the Ambulance Service. This was carried out through the East Midlands Scrutiny Network. The survey revealed that the consultation was to be discussed at Health Overview and Scrutiny Committees. Newark and Sherwood District Council were also scrutinising EMAS and the consultation was to be discussed. Nottinghamshire County Council Health North Committee was scrutinising EMAS' rural response times. The survey also provided a base of previous reports on East Midlands Ambulance Service from which to gather information.

3.2.2 Survey of the Ambulance Services in England

The Panel wanted to gather some key information from the other Ambulance Services in England to ascertain the resources, costs and tools used by them to compare with EMAS. Five services responded to the survey and provided a range of information. EMAS is not the largest ambulance service in England and in terms of population is most closely linked to South East Coast Ambulance Services NHS Foundation Trust; however the geographical area covered by EMAS is much larger.

The information gathered showed that the majority of the ambulance services still had ambulance stations and where there had been closures these had been no more than ten closures and these had been replaced with Make Ready Centres and Ambulance Community Response Posts. It was clear that changes are being made in other ambulance services but that it is a more mixed approach than the EMAS approach. None of the services reported closing all of their stations to replace them with Hubs and CAPs.

The survey showed that there was some use of System Status Management in other ambulance services. System Status Management was used in the USA to improve performance.

"System status management refers to the formal or informal systems protocols and procedures which determine where the remaining ambulances will be when the next call comes in" (Stout 1983). It is a system of sophisticated resource management targeting deployment of mobile resources within economic and clinical goals.[2]

3.2.3 Survey of the local community

A survey was launched on 3rd October to gather the views of local people, EMAS staff and NHS employees and closed on 3rd December. People were asked five questions. The questions and the results of the survey are in Appendix 1. The survey was available online via the Council website and in hard copies available in a range of places such as the Council One-Stop Shops, Parish Councils, Information Centres, GP practices and Public meetings about the Ambulance Consultation 'Being the Best'.

We received 120 responses to the survey, 80 online and 40 completed hard copies. The vast majority of the respondents were members of the public (96.6%) and a small number of NHS employees. Over 80% reported being satisfied or very satisfied with the current service provided by EMAS. Around 65%, who had experienced using the service, said the ambulance arrived within 20 minutes and a further 15% said it arrived within an hour. The response to the proposed changes to the Ambulance Service in Bassetlaw was of deep concern that these changes would negatively impact on current response times and would cost lives. There was also a clear request for staff and resources to remain in the district.

3.3 Freedom of Information requests

Throughout the review information was gathered through Freedom of Information requests, this was particularly to gain information from other Ambulance Services so that we could compare similar information with information gathered from witnesses. The review wanted to compare the cost of Private Ambulances, overtime and expenses so this information was requested from three other services Yorkshire Ambulance Service (YAS), West Midlands Ambulance Service (WMAS) and North East Ambulance Service (NEAS) (Appendix 2).

The information collected shown below shows that EMAS spends more than some of the other services on overtime. EMAS and WMAS who currently use the proposed model in 'Being the Best', have the highest spend for private/voluntary ambulances. EMAS informed us that if the proposals are adopted then the skill mix would be different and this would increase vacancies to 125 posts.

[2] The Performance of Staffordshire Ambulance Service – A review, Janette Turner and Jon Nicholl

April 2010-Mar 2012	**EMAS**	**YAS**	**WMAS**	**NEAS**
Overtime	£22,512,291	£22,688,380	£19,228,874	£13,261,282
No. Employees	2,700	4,300	4,000	2,000
Private/Voluntary Ambulances Providers	8	14	5	7
Costs for Private/Voluntary Ambulances	£6,911,722	£1,514,391	£8,761,162	£1,501,692
Unfilled vacancies (Sept 2012)	53	339.29 (WTE)	72.37 (WTE)	215 (WTE)
Transformation costs	£2,739,58	£112,800	£7,995,938	£56,174

3.4 Letters

The Health Panel was very proactive during this review and wrote several letters to the EMAS Board of Directors. The Panel formally took part in the consultation process and provided a body of evidence to support the response. On receiving the consultation response papers the Health Panel sent another letter to highlight their concerns regarding the consultation response report and how the responses were being interpreted (Appendix 3).

The Chair also sent in questions to be asked at the Public Board of Directors Meeting on 28th January and the Panel will submit further questions to the Board of Directors meeting on 25th March once the details of the proposed business case are published.

4. Addressing the Scope: Evidence Gathered for Recommendations

4.1 To review the Emergency Ambulance Service within Bassetlaw

Our concerns at the start of the review

Worsening service for patients
Longer waiting times
Funding for higher demand

The Evidence – What we gathered

4.1.1 The Commissioning of the Service

NHS Bassetlaw jointly commissioned the Emergency Ambulance Service along with the other nine Primary Care Trusts in the East Midlands region. East Midlands Procurement and Commissioning Transformation (EMPACT) manage the NHS contract. The contract is for three years and began in 2011/12. The contract covers the whole of the East Midlands. The total cost of the East Midlands contract is £131 million of which £3.52 million is Bassetlaw's share. This equates to 2.7% of the overall contract. Next year the Primary Care Trusts will be replaced by the Clinical Commissioning Groups (CCG) of which there are around 24. There are efficiencies with commission collaboratively as opposed to individual contracts.

A set number of planned responses are included in the contract value. These are:

- Calls
- Hear and Treat
- See and Treat
- See Treat and Convey

If there are more calls than planned then they are charged at a marginal rate and not the full cost of the call. There are contingencies in place to manage higher demand.

The national contract allows for the Commissioners to serve notices to the Ambulance Service if it has not met its performance targets. Where the contract is over performing and the targets are missed then penalties can be imposed. However, by taking money out of the Service this puts pressure on the Ambulance Service to meet future targets.

The national contract is inflexible and Bassetlaw has a different demand profile to more urban areas in the East Midlands where it is easier to meet targets. It is more difficult to get resources into a rural district like Bassetlaw. The district sits on the border of the Yorkshire Ambulance Service (YAS) and the care pathways used are often in the YAS patch. The CCG is investing in this service but is unable to ring-fence funding so that resources stay in Bassetlaw. To change the contract the Department of Health would need to sanction changes so the contract could work outside of the national contract rules.

Recommendation:

That the Clinical Commissioning Group should explore and participate in future changes to commissioning which will better suit Bassetlaw's needs.

4.1.2 Categorisation of Emergency calls

When a call is received by the Emergency Medical Dispatchers (EMD) at EMAS it is important that the calls are categorised correctly, this is achieved by asking a set of questions using software to ascertain the patient's condition. The call is then categorised and a vehicle is dispatched. The Emergency Medical Dispatchers are not clinically trained but have experience and expertise in talking to people, as well as the software, the EMD has trained nurses and paramedics on hand to assist with the call and the categorisation can be changed if the patient's condition deteriorates or improves.

The Department of Health introduced a set of 11 clinical quality indicators to replace the category B Calls for ambulance services in April 2011. These focussed on the outcome and the appropriate clinical approach (a full list of the indicators is available at Department of Health).

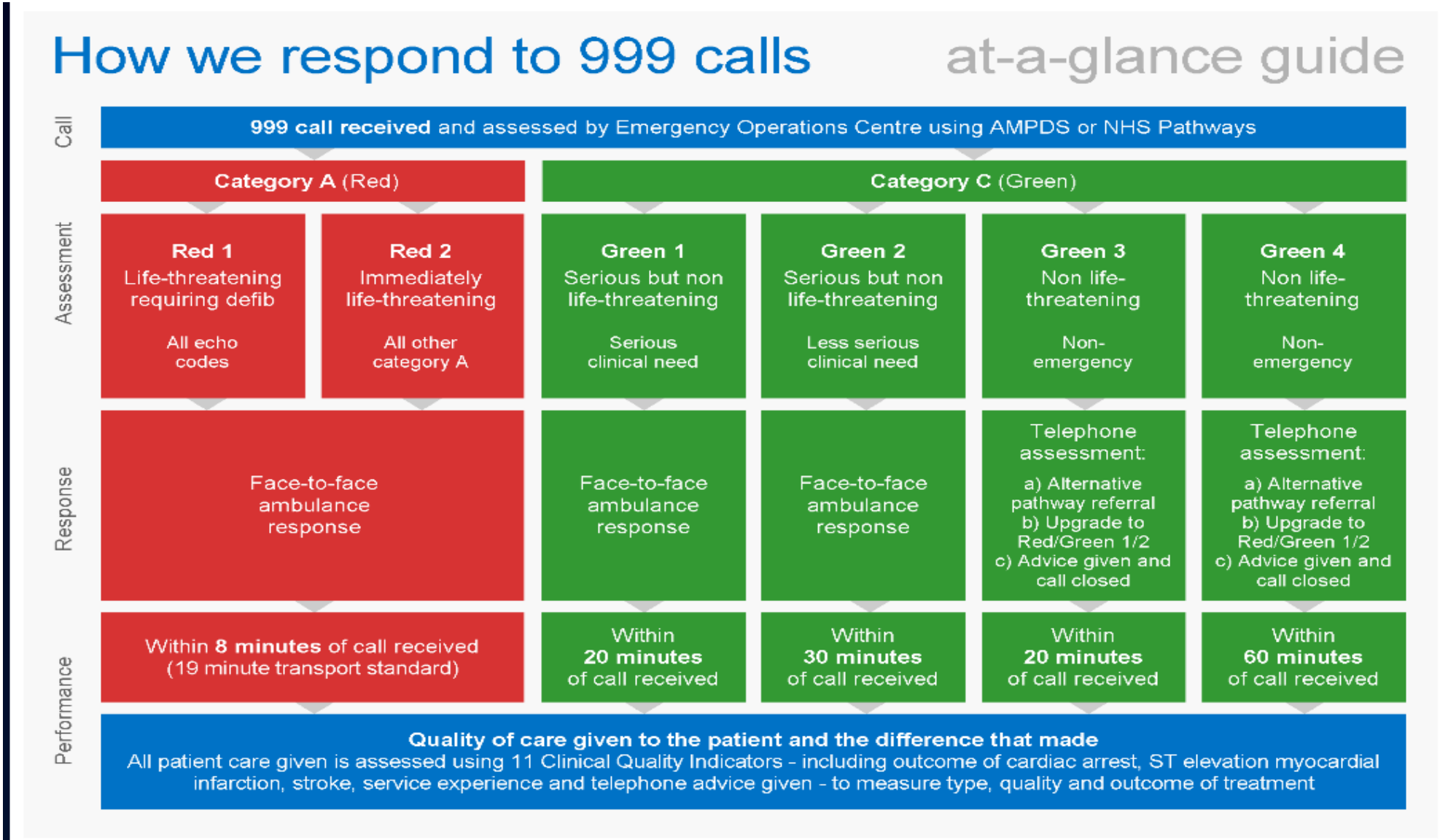
Calls are categorised in the following way:

- Red Calls (R1 and R2) – immediately life-threatening conditions which require a fully equipped ambulance
- Vehicle to attend the scene (R1 calls also require a defibrillator)
- Green Calls (G1 and G2) – conditions which are not immediately serious or life-threatening, but require a face to face response
- Green Calls (G3 and G4) – non life-threatening conditions which require telephone clinical assessment, where the patient will either be referred to an alternative care pathway, given advice over the phone or upgraded to a more urgent call category

The Red categories have a national standard whereas the response times for the Green Categories are not national standards, but are based on best practice. In some cases patients are treated over the telephone by a trained nurse or practitioner based at the call centre or will be referred to an alternative local health provider.

The diagram below shows the different categories of calls and how they are responded to. The Panel heard that only 1% of 999 calls are for cardiac arrests outside of hospital (when the heart stops). In Appendix 4 there is a guide which shows the whole process from the call through the categorisation process and the response times.

Figure 1: How we respond to 999 calls



Call Categorisation Chart 2011

CLOSE

4.1.3 Community First Responders

The Community First Responder scheme began in 1999[3], their primary role was to start cardiopulmonary resuscitation and use an automated external defibrillator where necessary. However, their role has developed over time. A Community First Responder (CFR) is generally a layperson, although some may be healthcare professionals. They are not employed by an ambulance service, but act on behalf of the service when responding to a call. Community First Responders are volunteers who are trained in basic life support and how to use a defibrillator as a minimum. A qualified paramedic or ambulance technician is always assigned to the call at the same time as the CFR, and will respond as quickly as possible, taking over the care and management of the patient on arrival and transporting them to hospital if required.

They are called out to attend Category A 999 emergency calls these are usually asthma attacks, heart attacks, strokes, breathing difficulties seizures chest pains and choking. The call centre pass calls to CFRs who are local and can often get to a patient quicker than an ambulance. However, in some cases a CFR may have to travel further. The CFR can defibrillate a stopped heart and use first aid to resuscitate a patient. They stay with the patient until the ambulance staff arrives. This can be up to two hours in some cases. The CFRs are not used in place of the Ambulance Service but supports the service.

There are currently 29 CFRs as at January 2013 in Bassetlaw, and they cover the following areas:

• Carlton in Lindrick	2
• Clarborough	3
• Harworth	3
• Misterton (Covering the surrounding 5 villages)	13
• North Leverton	1
• Retford	7

Survival rates in rural areas increase from 10% to 40% for cardiac arrest when there is a Community First Responder Group[4]. The chain of survival depicted below shows the key sequence of events for survival of a cardiac arrest. There is evidence to suggest that in cases of cardiac arrest, for every minute that goes by without defibrillation a patient's chances of survival decrease by 10%[5].

[3] Healthcare Commission: The role and management of community first responders
[4] Lives
[5] Improving survival from sudden cardiac arrest: the “chain of survival” concept

Figure 2: Sequence of events in emergency cardiac care is displayed schematically by "chain of survival" metaphor.

The review heard that there are primarily two groups of Community First Responders in Bassetlaw. These are in Retford and Misterton. CFRs in Retford are provided through the St John's Ambulance Service. The volunteers in Misterton are part of the Five Villages Responders scheme and are trained by EMAS. The responders are asked to give a minimum of four hours per month but many give much more time. Volunteers receive a high visibility vest and refresher training. CFRs do not get petrol expenses or a uniform. Some groups like the Five Villages Responders fundraise and provide volunteers with uniforms equipment and expenses. Other groups of CFRs recruited through national charities reported fundraising but not seeing any resources coming to the CFRs as it was going into the main charity pots. There appears to be quite a gap between the various groups in terms of expenses. Those in groups who are able to get a uniform believe it helps people differentiate them from ambulance service staff as well as looking presentable.

CFRs are part of the frontline services and are using their own resources to attend emergencies so they can help save people's lives. EMAS measure CFR response times when attending A8 calls and these are attributed to meeting the national targets.

There are examples of other CFR groups in the East Midlands Region that have been highly successful in providing this service in particularly rural areas. In Lincolnshire, the Lincolnshire Integrated Voluntary Emergency Service (LIVES), which began in the 1970's with a group of GPs, has developed over the years and now includes Community First Responders that are medics and volunteers. They have 612 volunteers and 162 groups across Lincolnshire. Last year they attended 18,000 calls and were the first on the scene in 86% of cases. They saved 207 lives. The organisation is highly regarded and professional and has its own Head Quarters in Horncastle. It costs around £750,000 per year to run the service. The local PCT recognise the contribution LIVES makes in the County and has commissioned the service and provides a third of the funding required, the rest is raised through fundraising activities.

The Panel believes that all CFRs should be reimbursed for their travel costs by EMAS and that there should be more investment in CFRs.

The information gathered indicated that there were no CFRs in the Worksop area and that there should be more volunteers in the rural areas. Phil Milligan Chief Executive said 'he would like there to be an explosion of CFRs'. Further education about CFRS and recruitment is necessary in the district to encourage more volunteers.

Recommendation:

That there should be further investment in recruitment and training of Community First Responders, including the provision for travel expenses and a uniform.

4.2 To understand why the Emergency Ambulance Service is not meeting targets

Our Concerns

Response times are not improving in Bassetlaw
Re-locating ambulance staff to Mansfield
Bassetlaw would have slower response times.
Increased turnaround times
Risks to patient care

The Evidence – What we gathered

4.2.1 How Performance is measured

There are two performance measures relating to Category A calls:

1. An emergency response within 8 minutes irrespective of location in 75% of cases (This is being increased to 80% in April 2013).
2. Where the patient requires an ambulance to transport the patient to a hospital, the ambulance must attend within 19 minutes of the request for transport (being made by the initial responder or being identified by the call taker, whichever is earlier) in 95% of cases.

The Department of Health further defines the measures as follows:-

For the purposes of the Category A 8-minute standard, an emergency response may only be by:

- An emergency ambulance: or
- A rapid response vehicle equipped with a defibrillator to provide treatment at the scene: or
- An approved first responder equipped with a defibrillator, who is dispatched by and accountable to the ambulance service; or when a healthcare professional is at the location of the incident, equipped with a defibrillator and deemed clinically appropriate to respond by the trust. A first responder is not a substitute for an ambulance response and an ambulance response should be dispatched to all calls attended by an approved first responder.

For the purposes of the Category A 19-minute standard, transport is defined as:-

- “A fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.”

Calls are measured from the time the call is received by the call taker to the time either a paramedic, ambulance crew or a community first responder arrives at the scene.

Ambulance Services are required to meet national targets A8 and A19 response times on average for the whole of the region they cover. There is no requirement to meet these targets at a county or district level. This means that if EMAS attains the required

standards for response times regionally it will be judged as delivering the national standards even if the performance in individual counties or districts is below target.

4.2.2 Response Times

The review gathered information that showed that EMAS was now close to achieving the national response times for A8 (75%) and A19 (95%) calls. However, this was on a regional basis only which is the standard set for Ambulance Services. They are not held to account for county or district level response times. The review looked at the response time data on a divisional level and district level and it was clear that Bassetlaw response times for A8 calls were well below the target. Nottingham City has a much better response rate see Appendix 5. It is clear that over performance in urban areas mitigates for poorer performance in the rural areas. EMAS has to meet the target for the region or it receives a financial penalty.

Table 1: A8 & A19 Response times

Locality	2011/12	Apr 12	May 12	June 12	July 12	Aug 12	Sept 12	Oct 12	2012/13 Total
A8									
NHS Bassetlaw	71.5%	68.0%	70.0%	72.0%	67.0%	65.8%	67.5%	64.0%	67.8%
EMAS	75.2%	75.5%	73.7%	75.6%	75.1%	75.5%	75.7%	74.8%	75.1%
A19									
NHS Bassetlaw	92.3%	93.0%	93.0%	97.0%	93.0%	94.0%	92.5%	91.0%	93.4%
EMAS	92.3%	95.1%	94.1%	95.3%	94.1%	94.3%	94.1%	94.4%	94.5%

According to the National Audit Office 'Rural areas present inherent challenges for an efficient, fast-responding service because calls are less frequent and widely spaced. When performance is broken down to the level of individual primary care trusts, we

found that in 2009-10, the category A8-minute response target was met in only one-quarter of the most rural 25 per cent of primary care trusts. In comparison, the target was met in just under two-thirds of the most urban 25 per cent. There was, however, a wide range of performance even in areas with the same level of population density and population clustering, which indicates there is scope for services containing more rural areas to learn from each other'.[6]

It was reported by local healthcare professionals that there had been a marked change in the response times, which had led to concerns. The Bassetlaw Clinical Commissioning Group, which is made up of local GPs became concerned about the service and its performance. They decided to put together a seven point plan to improve the service. This included weekly teleconferences with EMAS and meeting with Doncaster and Bassetlaw Hospitals NHS Foundation Trust, EMAS and commissioners to find a way forward. However, there has not been any significant improvement. Chief Operating Officer from the Clinical Commissioning Group spent a day with a local crew, which proved to be extremely informative and he has reported his observations to Phil Milligan and further discussions are taking place. The Commissioners are also exploring how some resources might be ring-fenced in the district to improve the service.

During our evidence gathering sessions local EMAS staff reported that they were travelling further afield than they used to. It was more common for vehicles to come from Derbyshire, Lincolnshire and South Yorkshire. The solo responders reported having to wait for up to two hours for an ambulance to attend to convey patients to hospital.

Response times are not outcome focussed and currently the A8 targets have no clinical value. There was common agreement by those involved in the review that these targets should be reviewed by the Department of Health. The Welsh Parliament has already ordered a review of their response times. There was a discussion in the House of Commons on 21st January 2013 when the Secretary of State, Anna Soubry, called for an urgent review of the Ambulance Service[7].

[6] Transforming NHS ambulance services – National Audit Office
[7] http://www.parliament.uk/

Recommendation:

That all response times in Bassetlaw should meet the national standards.

That the Chair of Overview and Scrutiny should lobby the Department of Health to review the Ambulance Service as a whole in relation to the response times.

4.2.3 Turnaround Times

In hospitals where turnaround times are high, EMAS is not always able to provide timely responses to new emergency calls in the community. This ultimately can impact on patient safety. Therefore, it is important that they are carried out speedily by all the parties involved. There is an agreed turnaround target of 25 minutes. This is broken down into two parts pre-clinical and post-handover.

A pre-clinical handover is classified as the time from ambulance arrival at the hospital emergency department to the point at which the ambulance staff handover the clinical responsibility for the patient to the hospital. This should take no longer than 15 minutes. The hospital is given a pre-alert and estimated time of arrival for patients with a life threatening condition. This gives them time to prepare the resuscitation room and page staff. The other arrivals are given a rapid triage and handover from the ambulance crew. This element is the responsibility of the hospital.

A post-handover is the time it takes the ambulance staff to call free from when they formally signed the patient over to the hospital. The current target for post-handover is 10 minutes. This element is the responsibility of EMAS Ambulance crews.

Delayed handovers are carefully monitored by the A&E Sister and the Operations Manager. Bassetlaw Hospital is currently failing to reach the turnaround targets set. This means that this has an impact on response times and could incur a financial penalty in the future. EMAS has already agreed to inpose penalties on hospitals that are not meeting the turnaround times retrospectively. This will bring in around half a million pounds in penalties. As Bassetlaw is part of the Yorkshire and Humber Strategic Health Authority, these penalties have not been agreed as part of the contract as yet.

The Panel heard that there were a number of issues at Bassetlaw Hospital which meant that turnaround times were not meeting the target.

Broadband connection

The Ambulance drivers have a 'Toughbook' (a computer specifically designed to reliably operate in harsh usage environments and conditions), which downloads electronic patient records through a docking system. This generally should take a few minutes but at Bassetlaw this has been taking considerably longer due to poor broadband connection. The hospital is looking to see if relocation of the docking station would improve the broadband connection.

Handover Paperwork

It was reported that ambulance crews had different approaches to the handover paperwork. Some of the crews start the paperwork in the ambulance on route to the hospital while others wait until arriving at the hospital. The handover cannot be completed until the paperwork is finalised and signed off by the hospital staff.

Resources

Another issue that can hinder turnaround times is the lack of resources; this could range from available staff, trolleys or beds. It is the job of the Operations Manager to ensure the correct amount of resources is available to ensure the flow of patients is not impeded. A handover can be delayed if there is a shortage of staff or if there is a lack of trollies to move the patient to. This can be exacerbated if there are lots of patients waiting for a bed on a ward.

High demand

If there is high demand and there are not the resources available to handle the demand this can also hamper turnaround times. A&E Departments at Bassetlaw and Doncaster have high demand. The Panel heard anecdotal evidence of patients being queued up on trolleys and ambulances having to wait to handover patients. When a hospital becomes too full they have to close the doors to new patients and they are diverted to another hospital close by. So if Doncaster reaches capacity then all emergencies would come to Bassetlaw, which then means that Bassetlaw will see high demand which in turn affects turnaround times.

It was also noted that the post-handover targets were not being met by the Worksop and Retford ambulance crews. EMAS has been working with staff and hospitals to improve turnaround times, but it is clear from the data in Appendix 6 that the post-handover times are significantly missing the target by between three to six minutes, compared to Bassetlaw Hospital which is missing the target on one to two minutes over target.

Currently this information is provided by EMAS who gather the times via staff and the 'toughbook'; this is given to the Clinical Commissioning Group on a daily basis. However, EMAS has been working with hospitals and commissioners to improve the turnaround times. In the next year a new system is to be put in place that will measure the turnaround times more accurately. Radio-frequency identification (RFID) is to be used to time stamp the arrival and departure of ambulances at the Emergency Department. The use of a wireless non-contact system that uses radio-frequency electromagnetic fields to transfer data, removes the need for human intervention to record times.

The issue of turnaround times is a problem for many Ambulance Services not just EMAS. The NHS Confederation produced the report 'Zero tolerance – making ambulance handover delays a thing of the past'. This report clearly articulates that long delays in handing patients over from the care of ambulance crews to that of emergency department (ED) staff are detrimental to clinical quality and patient experience, costly to the NHS, and should no longer be accepted. Sir David Nicholson, Chief Executive of the NHS told senior ambulance service leaders and commissioners that he would like to see long ambulance handovers treated as seriously as patient safety "never events" and was considering how it might be achieved. The term "never event" has a specific meaning within the NHS policy and contracting context, where such an event is defined as a "serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers." [8] The report highlights that delayed handover is a shared responsibility and that there needs to be commitment from all involved including the public. Overcrowding of Accident & Emergency departments with non-urgent conditions better treated by alternative healthcare providers puts a strain on staff and resources. Commissioners and primary care providers need to ensure that patients are aware of these alternative provisions and are actively encouraged to use them in preference to the Accident & Emergency Department. Equally there needs to be robust performance management in place with consistent penalties for failing to meet targets.

Recommendation:

That the Commissioners, Primary Care Clinicians and the Hospital work together to ensure that patients are clearly signposted to the appropriate care pathways and reduce the numbers of non-emergency patients attending the A&E Department.

That EMAS continue to work on the post-handover target which is currently not being achieved.

Bassetlaw Hospital needs to further improve turnaround times and avoid future financial penalties. The progress of turnaround times at Bassetlaw Hospital should be reported to the Annual Health Summit (or OSC).

[8] NHS Confederation - 'Zero tolerance – making ambulance handover delays a thing of the past'

4.3 To understand the proposals for changes to the service fully and its impact on Bassetlaw

4.3.1 'Being the Best' Consultation

Our Concerns

The distance to the Hub will slow down responses
That vehicles and staff will be based at Kings Mill and will be diverted from the district
Travel times for staff
Ambulances would be diverted to the urban areas.
Local knowledge would be lost
Resources would not be readily available in the district
Reduced resources in Bassetlaw
Slower response times
Risk to patient safety
Adequate provision in growth areas i.e. Harworth, Retford and Worksop
Reliance on cross border support

The Evidence – What we gathered

The proposals put forward by EMAS were part of a change to the management structure, working patterns and the estate. The proposal included changing the model for vehicle dispatch by replacing the existing 66 ambulance stations with 13 Hubs and 131 community Ambulance Posts. Staff would start their shifts at the Hub by collecting their Ambulance, which would be clean and fully stocked. The Hub would provide staff with access to support and training. Clinical staff no longer would clean and stock the vehicles. The Community Ambulance Posts (CAP) would be points strategically positioned. Process Evolution evidence based simulation software has been used to identify these locations. By using current statistics on calls locations and distances the software can produce scenarios to map out point that would optimise resources and improve performance.

The CAPs would be a portacabins style building where crews could have their break. These portable buildings mean they can be moved if necessary unlike the existing ambulance stations. It was EMAS' contention that these changes would improve performance and that there would be no additional cost in building the Hubs and CAPs as this would be offset by the sale of the existing ambulance stations.

4.3.2 The Closure of the Ambulance Stations

These proposals translated into the closure of both of the Ambulance Stations in the district and with a Hub at New Mills Hospital Mansfield and three Community Ambulance Posts in the district in Retford Worksop and Langold. This means that the Hub would be located between 16-25 miles away from the CAPs. YAS currently uses a Hub model but unlike the proposed EMAS model the Hubs are no more than between six to eight miles from the CAPs.

All of the stations were surveyed in 2009 by NIFES Consulting Group in accordance with Department of Health Estatecode guidance using the six facet methodology. The six facets are;

1. Physical condition
2. Energy efficiency
3. Compliance with statutory and non-statutory standards
4. Functional suitability
5. Space utilisation
6. Quality

Each facet is given a category as shown below. The Panel were informed that both of the Ambulance Stations in Bassetlaw had C or D categories under a number of the six facets.

Table 2: Estatecode Categories

The Six Facet categories from Estatecode	
A	As new and compliant with statutory requirements
B	Sound, operationally safe with no major changes necessary
C	Operational but major repair or replacement needed within one year for engineering and three years for building elements
D	Unacceptable – serious risk of breakdown
X	Replacement needed

It was estimated that the Bassetlaw stations would need £360,845 of improvements to meet the necessary standards. The estates plan reported that the maintenance backlog would cost £13 million to bring the current estate up to standard. The cost of implementing the new proposals was said to be £28.5 million and could be covered by the sale of the existing stations.

Bassetlaw would lose both of its stations under the current proposals and would have three Community Ambulance Posts which would be portacabins estimated at £30,000 each. The stations are situated on prime sites and the revenue gained from the sale of the stations would not be spent on Bassetlaw but would go to fund the Hub outside of the district. This also means that all resources would be stored at Mansfield.

It was also reported that some of the current ambulance stations in the East Midlands are not situated in locations that can readily access the main road networks. This is not the case with the stations in Bassetlaw; they are both situated on roads that lead out of the towns and link directly to the A57 and A1.

4.3.3 Staff Concerns

During the two daytime scrutiny events the Health Panel spoke to a number of EMAS employees from Bassetlaw and further afield. The Panel wanted to gain a staff perspective on the current working conditions and how the Ambulance Stations were being used.

Staff reported the following:

- More solo staff vehicles unsuitable for conveyance
- Shortage of ambulances with double crew members
- Two hour delays for conveyance of Category A8 patients.
- Greater use of open radio communication from staff needing urgent assistance, where control room has no available vehicles
- Travelling further afield for specialist centres
- Driving for longer periods of time.
- Time spent in ambulance stations varies on work load on average 30% time spent in the station or standby point.
- Bassetlaw area has 40% staff cover due to sickness and vacancies.

The staff reported that they were often too busy to take breaks or had no facilities to get a hot drink or go to the toilet if they were at a standby point.

The Panel then asked the staff for their views about the proposals to close the ambulance stations in Bassetlaw and replace them with three standby points and a Hub based at Kings Mill Hospital, Mansfield. All of the staff had concerns about the proposals. The key issues were the distance of the Hub from Bassetlaw and how this would affect the service in the district. Staff believe that the urban areas would draw resources leaving the rural areas vulnerable.

All staff would have to travel to Mansfield to collect their vehicles and return at the end of the shift to drop them off. This would increase staff travel to work times. In the proposals presented to the EMAS Board it was reported that the impact on staff travel on the average travel time now 17.4 minutes would increase by around 3 minutes[9]. Process Evolution estimated that 57% of staff would incur an increase in travel times and 20% of the workforce would have to travel more than 30 minutes to the nearest Hub[10]. From the estimations gathered from the AA Route Planner during the review, Bassetlaw crews would be travelling on average more than 30 miles and would have significantly increased their travel times:

[9] EMAS Supporting Paper 1 Estates Plan Supporting faster responses page 7 (point 5.6)
[10] Process Evolution Report into Estates Strategy Optimisation and Modelling for EMAS

- Retford to Kings Mill Hospital 25.1 miles, travel time 43 minutes[11].
- Worksop to Kings Mill Hospital 16.3 miles, travel time 26 minutes
- Harworth to Kings Mill Hospital 32.9 miles, travel time 44 minutes

The Panel believed that in light of increased driving during the shift the extra travel times to work could pose a health and safety risk to staff.

The crews pride themselves on the local knowledge they have gathered about the district and their patients. This would be a considerable loss if they were distributed outside of the district. Whilst crews do have satellite navigation to find addresses, this is not always helpful and local knowledge can save valuable minutes.

The logistics of having the Hub at Mansfield also throws up issues of access to extra equipment, change of clothing for crews and cleaning of a vehicle in the event of contamination. It also means that Community First Responders would no longer be able to get supplies from the stations.

EMAS said that the Hub would provide staff with the following benefits:

- Staff and team leaders will have the opportunity to meet regularly at the beginning and end of shifts
- Access to support from colleagues
- Better communication
- Improve the way we clean, service and re-stock vehicles, so that they are ready at the start of the shift.
- Provide training facilities on site.

Recommendation:

That EMAS should reconsider the proposals set out in their consultation 'Being the Best' with immediate effect.

That the Ambulance Stations in Bassetlaw should remain open

That Bassetlaw should retain Emergency Ambulance Service resources locally.

[11] AA Route planner

4.3.4 Cuts in Resources

The Panel heard that EMAS had received financial penalties over the last few years, including £5m in May 2011 for failing to meet the 75 per cent annual target for reaching category A calls in 8 minutes 2010/11. There was a further £2.5m penalty given in May 2012 for missing its target of reaching 95% of all emergency calls within 19 minutes during 2011-12[12]. EMAS also recently lost the Patient Transport Contract for a large part of the region, which was worth £130m over five years.

EMAS services are commissioned by six Primary Care Trust (PCT) Clusters, made up of eleven PCTs who hold a service contract with EMAS based on service cost and volume. The current annualised income across these contracts is £164.million, including Patient Transport Services (in North East Lincolnshire). The NHS must save circa £20bn over the next four years and therefore EMAS has to reduce costs by 20% over the next five years[13] .

[12] Derby Telegraph
[13] Annual Plan 2012/13

There has been an annual increase in call volume of 5%; over the last 5 years. The table below shows the percentage changes year on year.

Table 3: Year on Year % Changes

Calls	2007/8 to 2008/9	2008/9 to 2009/10	2009/10 to 2010/11	2010/11 to 2011/12
All Calls	5.63%	3.82%	4.41%	7.26%
Cat A Calls (R1 & R2)	7.35%	4.34%	11.28%	13.46%
Cat B Calls (G1 & G2)	5.50%	4.50%	0.42%	-14.76%
Cat C Calls – Public (G3 & G4)	8.39%	6.90%	6.90%	50.64%
Cat C Calls – Healthcare Professionals	-1.67%	-4.07%	-5.43%	-7.51%

(This table details the old call categorisations first to give an accurate picture of previous year's performance with the new categories being detailed in brackets for 2011/12).

The introduction of the 111 calls for non-emergency calls has also pulled on resources because of attending calls triaged by 111 as emergencies but on arrival that is found not to be the case. EMAS currently cannot re-triage a 111 call even when it has been assigned to them for an emergency dispatch.

EMAS has a number of areas where expenditure is increasing. Overtime is one such area of high expenditure EMAS spent £22,512,291 on overtime between April 2010 and March 2012. This is slightly less than the amount spent by YAS who have 1763 more employees and provide Patient Transport Service for a wider area than EMAS. WMAS' overtime costs are considerably lower despite more staff and a higher call volume.

Table 4: Overtime and Expenses Comparisons

	East Midlands Ambulance Service	Yorkshire Ambulance Service	West Midlands Ambulance Service	North East Ambulance Service
Number of Staff	2,700	4,463	4,000	2,000
Number of calls	1,388,340	1,484,182	1,709,348	871,012
Overtime	£22,512,291	£22,688,380	£19,228,874	£13,261,282
	includes patient transport for North and North East Lincolnshire	includes Patient Transport Services for the whole of Yorkshire	includes Patient Transport Services for North Staffordshire Heart of England NHS Foundation Trust University Hospitals Birmingham Worcestershire Coventry and Warwickshire Black Country Partnership	includes Patient Transport Services for all of the North East
Private/Voluntary Ambulances Providers	8	14	5	7
Private ambulance/voluntary Ambulance Costs	£6,911,722	£1,514,391	£8,761,162	£1,501,692
Unfilled vacancies	53	339.29 (WTE)	72.37 (WTE)	215 (WTE)
Transformation costs	£2,739,58	£112,800	£7,995,938	£56,174

(FOI Information based on period April 2010 - March 2012)

At the January (28th) Board of Directors meeting it was revealed that a third of the overtime during December was covering vacancies. EMAS is currently phasing in newly recruited staff which should address some of the vacancy issues. However, it is noted that if the proposals go ahead then the skill set of staff will have to change which would mean further recruitment and training would be needed.

Ambulance Services in England have the highest sickness rates in the whole of the NHS. It was recorded on average that Ambulance staff have 22.6 days sick leave per year.[14] EMAS has had a poor sickness record in the last year, but has made some improvement in the last three months.

EMAS contracts private/voluntary ambulance companies to assist during peak periods. The Review heard that these vehicles are currently housed in the district's Ambulance Stations. The information gathered showed that this was a common practice amongst Ambulance Services. However, what was more of a concern was the amount being spent on these contracts. EMAS spent £6,911,722 during April 2010-12 contracting private/voluntary ambulance companies, this is significantly more than neighbouring YAS.

During the review the Panel was told that each of these companies has a different skills base and that not all ambulances are able to convey emergency patients to hospital (e.g. blue light trained) and would have to wait for an EMAS crew to attend. The Panel believes that inefficiencies like this could be reduced by an increase in staff and vehicles, which could further reduce overtime and provide a more consistent approach.

The Trust estimates that running costs of a smaller more modern estate at the end of the five year programme will be reduced on a recurrent basis by approximately £548K per annum.[15]

[14] NHS Information Centre
[15] EMAS Supporting Paper 1 Estates Plan Supporting faster responses page 8 (point 6.2)

During the review it was announced that the number of double manned crews covering the night duty was to be halved and replaced with a solo crew. EMAS said it was re-aligning resources, not reducing services. However, this will mean that there is less ambulances on duty to convey people to hospital during the night.

Recommendation:

That there should be no cuts in the current service provision. Where EMAS insist that resources need to be cut or re-aligned the Health Panel expect a clear indication as to what alternative arrangements are in place, voluntary or otherwise, to cover the gaps left in resource provision. Any changes in provision should be reported to Bassetlaw District Council's Overview and Scrutiny Committee.

4.3.5 Economic Development

Bassetlaw District Council has set out in the Local Development Framework Core Strategy the details for growth and development in the district. Part of these plans includes over a thousand new houses in the Harworth area. Harworth is in the northern part of the district on the border with South Yorkshire. Currently residents are able to choose if they wish to go to Bassetlaw or Doncaster subject to resources. EMAS has a cross border agreement with Yorkshire Ambulance Service (YAS) and currently picks up less than one call a week for EMAS (see section 4.3.6). There is also further development taking place in Rossington that will further pull on YAS resources. The Panel heard that if the proposals were to go ahead that there is not currently a Community Ambulance Post or Hub planned for the Harworth area and ambulances would have to travel from farther afield. In light of the planned development and the increase in the local population (around 3,000) associated with this and possible further growth in the area the Panel were concerned that Harworth would be vulnerable. Elsewhere in the district there is also planned development in Retford, Worksop, Carlton in Lindrick and Misterton over the next five years (Appendix 7). It was also noted that there are 2,000 planned properties in nearby Gainsborough that would also stretch the Ambulance Service in this part of the region.

4.3.6 Cross Border Agreements

There is a national directive called the Cross Ambulance Trust Border Memorandum of Understanding Agreement between all Ambulance Services in England, to provide cross border cover when necessary. The overarching principle of this Memorandum of Understanding is:

"Nearest and fastest first response must be dispatched, irrespective of the organisation's operating boundaries."

It applies to all categories of call and there is a protocol for such incidents. It highlights that 'emergency calls to locations at/or near external operating area borders present a higher than normal risk for both patient and the Ambulance Service(s) involved. This procedure is designed to ensure that the risk from a break in continuity of care is kept to a minimum.' [16]

Bassetlaw is situated on the border of South Yorkshire. Harworth and Bircotes in the north of the district sits on the border of Yorkshire Ambulance Service's (YAS) operating area. The review heard that during the five months June to September 2012 there were 73 calls picked up by YAS; this equates to less than one call a day. Yorkshire Ambulance Service provided information about the cross border agreement and said that there was no extra capacity for them to attend any more calls for EMAS without it impacting on their service. EMAS has to manage their resources to ensure that all areas has sufficient coverage.

There is a concern that there will be more calls passed to YAS in the Harworth area if the proposals go ahead and ambulances are being diverted to urban areas and away from the rural areas. Panel Members concern is what will happen if YAS can't take the call.

Recommendation:

That EMAS reconsiders its cross-border arrangements with Yorkshire Ambulance Service to ensure there are adequate resources in place.

4.3.7 The Consultation Process for 'Being the Best'

Our Concerns

Public meetings were not publicised well
Too much reliance on the EMAS website
Hard to reach groups not catered for
Poor networking with partners

The Evidence – What we gathered

Website

[16] Cross Ambulance Trust Border Memorandum of Understanding Agreement

The review found that the main tool used for the consultation 'Being the Best' was the East Midlands Ambulance Service's website. It was here that the Freephone number to get a hard copy was advertised, if people wanted to respond by post.

Bassetlaw is amongst the districts in Nottinghamshire with the slowest speeds of broadband, and has many rural areas that have little or no broadband (see map at Appendix 8). This meant that Bassetlaw people with poor or no access to the internet had little opportunity to engage in the process.

The reliance on the website also meant that local people were not aware of the public meetings arranged by EMAS. The first meeting in Worksop was so poorly advertised that many interested parties did not find out it was taking place until the day before the meeting. This caused a lot of mistrust as local people perceived this as a ploy to minimise the opposition to the proposals.

This shows that there was a lack of knowledge about the areas covered by EMAS and the challenges of engaging with rural areas who have limited or no broadband access. It is also clear that preparation could have been better and that alternative methods of consulting were not considered.

Publicity

Following this meeting there were some items in the local press, but advertising was limited to the later public meetings. However other means of advertising the consultation process were not evident, for example, posters providing the freephone information or details of the public meetings, hand-outs or notices in local healthcare sites.

However, EMAS did attend meetings arranged by local councillors, which they did not seek to advertise on their website but included them as evidence gathering in their consultation process. It is clear that most of the publicity was carried out by local interested parties and local staff.

The Panel was aware that the consultation was not even communicated well with partners. The local Clinical Commissioning Group Patient Engagement officer was unaware of the public meetings; staff in the NHS who work on the frontline such as GP practices and nurses at the local hospital were unaware of the consultation. If there had been better networking with partners the consultation could have been better advertised.

It is the opinion of the Panel that hard to reach groups have not been catered for well in this district. This district has a large proportion of elderly people, Eastern European and those with poor literacy skills.

Public Meetings

The public meetings were well attended despite the poor publicity but it was evident after the first meeting at Worksop that better management of the meeting was needed. It was difficult to hear details of the proposals and for the public to participate.

EMAS did change the way the meetings were run by placing a local person of experience in to chair the meetings. This meant that there was more opportunity for local people to ask questions.

Quality of Information

The consultation document was a very glossy brochure with lots of photographs of the ambulance service but the information was very general and obviously promoted the new proposals. Some of the questions were poorly written and asked an open question but provided only closed answers as a response, or were unclear what they were asking. The return address was on the previous page and not on the page that was detached. This meant if the questions were photocopied for multiple uses the address was not on the page.

The consultation document does not show a picture of or diagram of a proposed Hub or community ambulance post. It does not explain how the consultation results will be analysed or how petitions are going to be handled.

Also, if you were replying by email you were not provided with an online form to submit. A simple online survey would of benefitted this consultation and would have helped with the analysis of the results. This document was the means to explain the proposals and for responses to be gathered and its weaknesses meant it may have deterred people from responding.

Recommendation:

That EMAS review their consultation process to ensure that it is improved and is not reliant on the Website and that there is a more joined up approach with partners.

4.3.8 Transparency

It would appear that health organisations do not have a national framework with regard to the publishing of papers prior to a public meeting, or a statutory time frame for the submission of questions from the public, as there is in a local government setting,

although all adhere to the principals laid out in The NHS Code of Conduct and Code of Accountability in the NHS (2004). Each individual organisation determines these processes in its constitution or standing orders. Hence, there are quite a range of practices across ambulance services in England.

Yorkshire Ambulance Service publishes their papers seven days prior to a public meeting and the public can ask a question at the meeting without prior submission. West Midlands Ambulance Service publishes their papers 5 clear days in advance of a public meeting and the public can submit questions seven days prior to the meeting or ask a question on the day.

All of the Ambulance Services have or are seeking to gain Foundation Trust status as this allows greater freedom in the decision making process. EMAS is currently going through this process. Foundation Trusts are not-for-profit, public benefit corporations, although they are still part of the NHS. They are not directed by Government so have greater freedom to decide, with their governors and members, their own strategy and the way services are run[17]. Foundation Trusts are regulated through Monitor and they follow the Code of Governance which includes the following principle:

'*The board of directors should appropriately consult and involve members, patients and the local community. Notwithstanding the complementary role of the governors in this consultation, the board of directors as a whole has responsibility for ensuring that regular and open dialogue with its stakeholders takes place. The board of directors should keep in touch with the opinion of members, patients and the local community in whatever ways are most practical and efficient.'*[18]

The Health and Social Care Act 2012 will also strengthen local accountability by requiring Foundation Trusts to hold Public Meetings.

The Health Panel believe that the EMAS protocol does not lend itself to public scrutiny because of the time constraints involved. The publishing of the papers and the submission date for questions barely gives individuals 24 hours to consider the papers and determine any questions that may arise. It was also noted that the EMAS papers are of a considerable volume which would further the need for more time for perusal.

Anecdotally this issue was raised by a member of the public at the Board of Directors meeting on 10th January, to which Phil Milligan Chief Executive of EMAS responded that EMAS were satisfied with the protocols in place.

The Panel would suggest that as EMAS is seeking to engage more with the public, that this process should be reviewed so that the public can more readily engage.

[17] What are Foundation Trusts?
[18] NHS Foundation Trusts' Code of Governance 2010

Recommendation:

That EMAS should review its current protocols regarding the publishing of Board Papers and the submission of questions by the public. The time period should be extended between the publishing of the papers for the Board of Directors Public Meeting and the deadline for submission of questions to five working days.

5. Conclusion

This review set out to examine the emergency ambulance service provided in Bassetlaw. This included understanding how performance is measured and why EMAS were unable to meet the national targets set by the Government. In light of this poor performance, EMAS had undertaken a complete organisational review which included the management structure, skill base and rotas and the estates.

The review highlighted the poor performance of response times in the district and the differences in service in rural areas compared to urban areas. Concerns had been raised about response times and the Bassetlaw Clinical Commissioning Group has been working with EMAS to seek a solution. The current commissioning framework does not provide opportunities to ring-fence resources for a district or area within a region and the Panel welcomed the CCG's desire to explore alternative options with the Department of Health to ensure the district gets the resources necessary to ensure an equitable service. The Panel supports the call for a review of national response times within the Ambulance Service overall.

Whilst looking at performance it became clear that this is a complex issue and that turnaround times were part of the problem. The Panel noted that Bassetlaw Hospital was failing the turnaround targets and gathered information from the hospital about some of the possible issues. Recently the A&E Department at Bassetlaw has been failing waiting times and an Appreciative Inquiry has taken place to ascertain what changes may need to be made.

The review gathered information to compile a response to the consultation 'Being the Best' and there were concerns about how the responses as a whole were interpreted by EMAS. The Panel welcomed the decision to delay the business case for further options to be investigated. However, the inclusion of local representatives in this process has been minimal and disappointing.

The Panel await the final decision of the EMAS Board of Directors on 25th March, which they hope will reflect the evidence and conclusions of this review. This report will go to Cabinet and the progress of the recommendations will be monitored for twelve months and reported to the Overview and Scrutiny Committee.

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7. Appendices

7.1 Appendix 1 – Patient Survey and Results

The following graphs and tables show the responses to the survey carried out during the review. The comments collected in respect of the EMAS proposals were submitted as part of the consultation.

The Questionnaire

Changes to the Ambulance Service In Bassetlaw

Your Views are Vital

The future of your healthcare service could be affected if the changes being proposed by East Midlands Ambulance Service go ahead. These changes include the closure of the Ambulance Stations in Retford and Worksop and replacing them with Community Ambulance Points (smaller base with reduced facilities), with a Super Hub (main Ambulance base which will house around 60 vehicles) being at Mansfield. East Midlands Ambulance Service says this will improve efficiency and provide better response times. We want to know what you think.

You can read more about these changes in the Consultation document "Being the Best" available from East Midlands Ambulance Service and take part in the Consultation by going to www.emas.nhs.uk

1. Which of the following best describes your status?

- ☐ A member of the general public
- ☐ A member of East Midlands Ambulance Service staff
- ☐ An ex-employee of East Midlands Ambulance Service
- ☐ NHS Employee

Other (please specify)

2. What has your experience been of East Midlands Ambulance Service (directly or indirectly)? Please give details below.

3. If you have required this emergency service in the past, how long did it take for them to arrive?

- ☐ Within 20 minutes
- ☐ Within an hour
- ☐ Within two hours
- ☐ More than two hours

Please provide specific details if available

4. Are you satisfied with the level of care/service provided by East Midlands Ambulance Service?

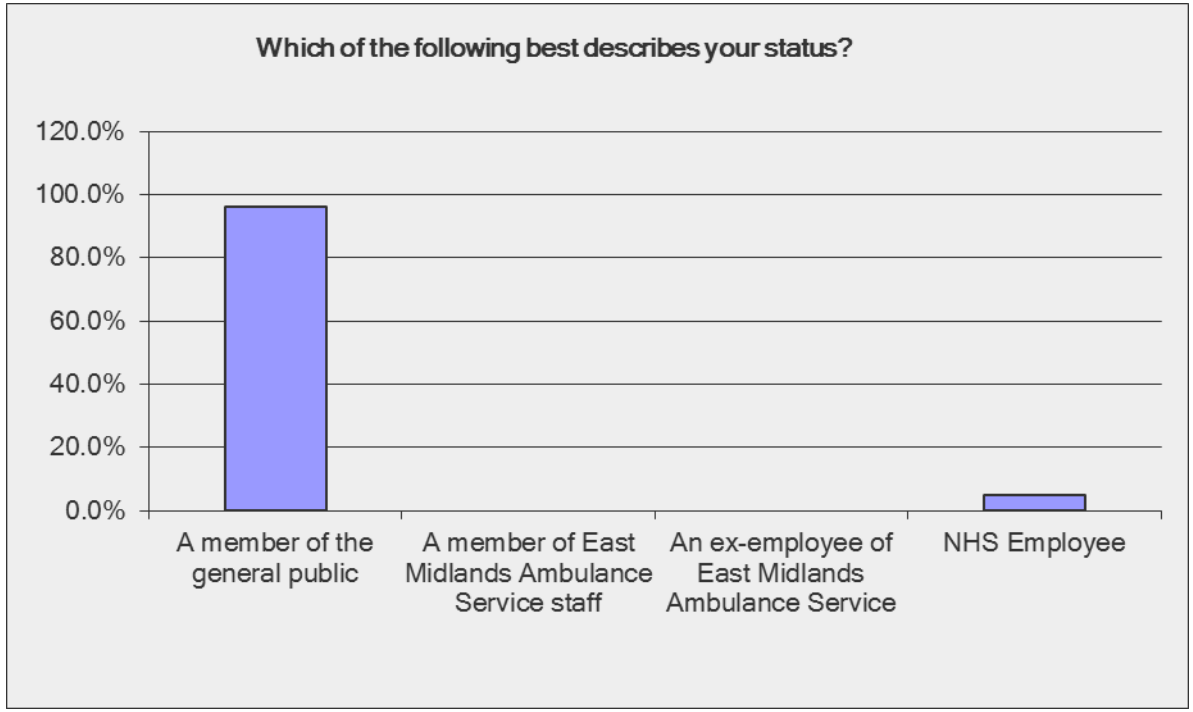
- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neither
- ☐ Dissatisfied
- ☐ Very dissatisfied

Please add your comments here?

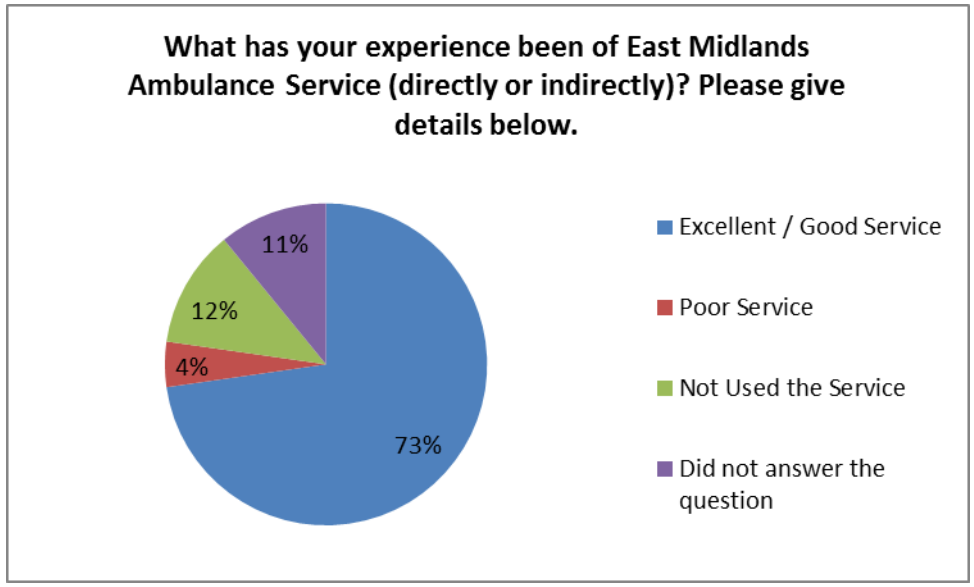
5. What is your opinion to the proposed changes to the Ambulance Service?

Please send your views to: The Policy Unit, Bassetlaw District Council, Queen's Buildings, Potter Street, Worksop, Notts S80 2AH

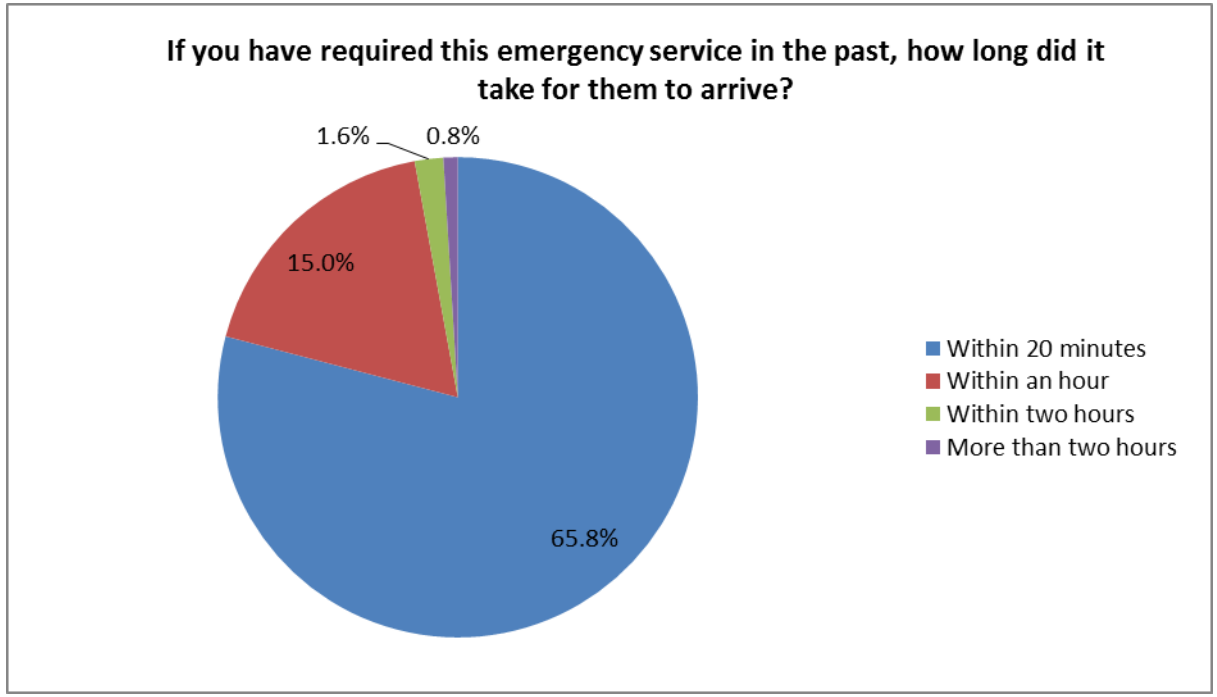
Question 1


Which of the following best describes your status?
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
A member of the general public
A member of East Midlands Ambulance Service staff
An ex-employee of East Midlands Ambulance Service
NHS Employee

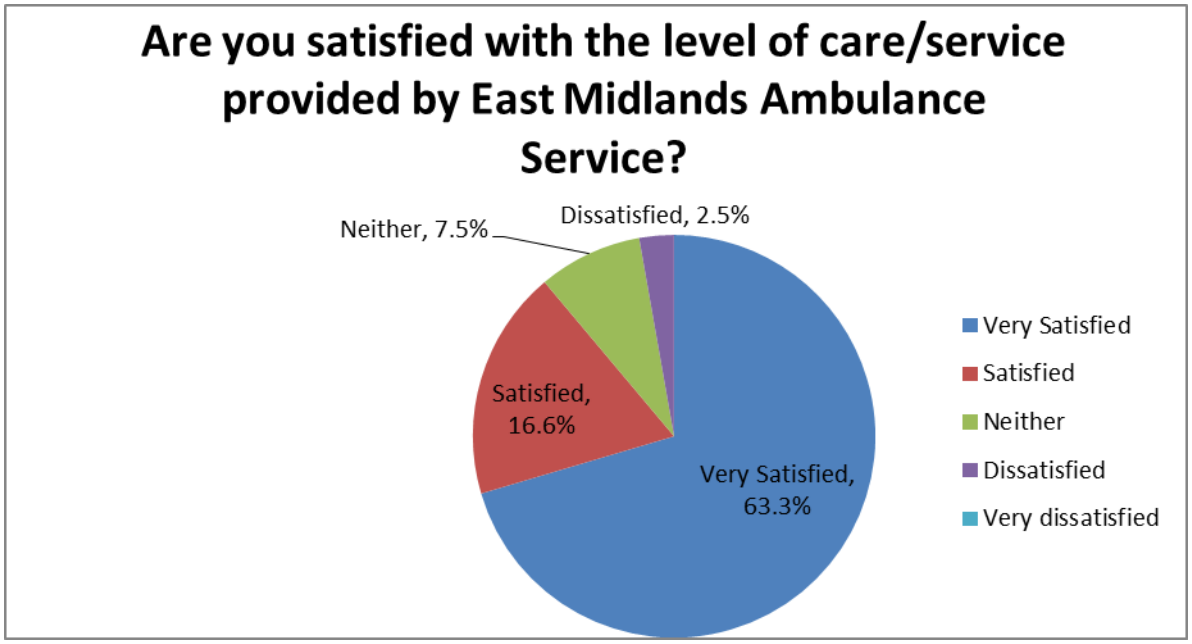
Question 2


What has your experience been of East Midlands Ambulance Service (directly or indirectly)? Please give details below.
11%
12%
4%
73%
Excellent / Good Service
Poor Service
Not Used the Service
Did not answer the question

Question 3


If you have required this emergency service in the past, how long did it take for them to arrive?
1.6%
0.8%
15.0%
65.8%
Within 20 minutes
Within an hour
Within two hours
More than two hours

Question 4



Question 5 - What is your opinion to the proposed changes to the Ambulance Service?

There were 119 responses to this question, with the vast majority of responses not in favour of the proposed changes. There were concerns that ‘it will definitely put Bassetlaw patients at risk if local stations are closed, with response times adversely affected’. Others were concerned that the proposals were to save money. There was a strong consensus that residents wanted to keep the service local. Of the few that were in favour of the proposals, they suggested co-location with the Fire Service and a trial run to see how it works.

7.2 Appendix 2 – Comparisons with Ambulance Services in England

All Ambulance Services in England were contacted with the exception of the London and Isle of Wight Services, the table below shows the information gathered.

Survey Questions for Ambulance Services in England.

	Question
1.	Name of Ambulance Service
2.	Population covered by the Service
3.	How your service is staffed i.e. (the roles in the service)?
4.	How much does the service cost each year?
5.	Please can you describe the current model being used by your Service to deploy emergency vehicles (e.g. System Status Management)
6.	How many Ambulance Stations/Hubs/ Tactical Deployment Points or any other bases do you have?
7.	How many Ambulance Stations have been closed in the last 5 years?
8.	If Ambulance Stations have been closed what have they been replaced with?
9.	Do your Ambulance Stations meet NHS standards of repair?
10.	Do the Ambulance Stations act as a base for other Ambulance/ Transport services?
11.	What is the protocol for 999 calls? Do you triage over the telephone?
12.	Who is contracted to provide Community First Responders for the Service?
13.	How many Community First Responders do you have? Do you have any areas where there are no CFR?
14.	As part of your service do you deliver the Patient Transport Service/ transfers?
15.	If yes do you have a dedicated fleet of vehicles for this?

Survey responses from Ambulance Services in England.

East Midlands Ambulance Service	North East Ambulance Service	South East Coast Ambulance Services NHS Foundation Trust	West Midlands Ambulance Service	South Central Ambulance Services NHS Foundation Trust	North West Ambulance Service (NWAS) NHS Trust
Population covered by the Service					
4.8 million people within Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire. 6,425 sq. miles	2.66 million people	Over 4.5 million people Covers a geographical area of 3,600 square miles (Brighton & Hove, East Sussex, West Sussex, Kent, Surrey, and North East Hampshire)	The area's population is approximately 5.3 million The Geographical area: 5000 sq. miles - 80% of which is classed as 'rural'.	3,743,836	NWAS is the largest ambulance trust in England, providing services to a population of seven million people across a geographical area of approximately 5,400 square miles.
How your service is staffed i.e. (the roles in the service)?					
We employ over 2,700 staff Emergency Medical Dispatcher (Control) Triage Nurse (Control) Paramedic (Accident and Emergency) Student Paramedic (Accident and Emergency) Emergency Care Practitioner (Accident and Emergency) Emergency Care Practitioners Emergency Care Assistant (Accident and Emergency) Community paramedics Technicians,	Paramedic Ambulance Technician Capped at Technicians Patient Transport Non-Emergency /Contact Centre staff Senior Managers	Emergency Care Support Workers 206 Paramedic & Critical Care Practitioners- 148 Paramedics 735 Technicians 764 Ambulance Managers 37 HART[1] Operatives 69 PTS [2] staff 318 Emergency Dispatch Centre staff 356 Support Staff and Management 458 TOTAL STAFF 3091	We currently employ over 4000 people. Technician Paramedic Paramedic Manager Paramedic Specialist Practitioner Emergency Care Assistant Emergency Care Practitioner Emergency Medical Dispatcher/Call Handler Health Care Support Worker Student Technician Technical Instructor Technician Trainee Practitioner Ambulance Care Assistant/Patient Transport Service Driver Apprentice Call Operator (Full list provided)		NWAS' core services are delivered through four distinct service lines – Paramedic Emergency Service, Patient Transport Service, Contact Centres and Resilience. Core service delivery is supported by a number of support service functions, including: Finance, Human Resources, Performance and Patient Experience, Healthcare Governance, Information Management and Technology, Training and Development, Fleet and Facilities Management and Communications and Corporate Governance.
How much does the service cost each year?					
In the 2011/2012 financial year, EMAS' budget for providing its services was just over £167 million.	**Approx. £100 million for the Trust (Emergency care; patient transport; contact centre)**	**Approx. £170 million**	2011/2012 - £194,644k, 2010/2011 - £194,242	£107,367,631	The total cost of running the NWAS service is £253.6m.

[1] (Hazardous Area Response Team)
[2] Patient Transport Services

East Midlands Ambulance Service	North East Ambulance Service	South East Coast Ambulance Services NHS Foundation Trust	West Midlands Ambulance Service	South Central Ambulance Services NHS Foundation Trust	North West Ambulance Service (NWAS) NHS Trust
Please can you describe the current model being used by your Service to deploy emergency vehicles (e.g. System Status Management)					
We use a computer based system called MIS C3. This is the incident management system that we use to control and deploy all resources to incidents. We use a System Status Management model which we update to reflect changing demand patterns. System Status Management allows any unallocated resources to be positioned on what are called “standby points” that allow quicker responses to incidents. The standby points are prioritised in each area so as to maximise coverage and patient care. We are currently revising our standby points across the area we serve.	NHS Pathways is used to triage 999 and 111 calls. The computer aided dispatch system is provided by CLERIC.	We are currently using System Status Management to deploy emergency vehicles.	We use a command and control computer aided dispatch system (CAD) called Cleric and a clinical triage system called NHS Pathways. The Trust does use system status management and is currently going through operational transformation projects to move towards a make ready system where resources are located centrally within the divisions and are stocked and cleaned ready for deployment. System status plans are utilised to put resources where they are required.	We operate the Intergraph ICAD dispatch system with a system status plan. The SSP is developed from a variety of information sources of historical data.	There is limited use of System Status Management (Cheshire and Merseyside only). Other than that, resources are deployed from stations, when they are mobile, or when they become clear at hospitals/calls.
How many Ambulance Stations/Hubs/ Tactical Deployment Points or any other bases do you have?					
76 bases at present	We have 51 ambulance stations covering an area of 3,200 square miles.	The Trust delivers the A&E and PTS operational service from 55 ambulance stations, 5 Make Ready Centres (MRC) (Hubs) and 44 Ambulance Community Response Posts (ACRP)	91 Ambulance Stations:		The Trust Headquarters is in Bolton, and there are four area offices serving the communities of Cheshire and Merseyside (Liverpool), Cumbria and Lancashire (Broughton near Preston and Salkeld Hall, Carlisle) and Greater Manchester (Bury). There are 109 ambulance stations distributed across the region, three 999 control centres, one patient transport service control centre, and two HART buildings (one being shared with Merseyside Fire & Rescue).
How many Ambulance Stations have been closed in the last 5 years?					
One ambulance station was closed (in July 2012) due to the loss of the Patient Transport Services Contract. This station was used purely for Patient Transport Services staff, and when they transferred over to the new provider, the building became redundant	5 (to the best of my knowledge).	The estate constantly changes to reflect the dynamic nature of our contracts. Thus, although we have closed 10 mal- located ambulance stations over the past 5 years, we have opened 5 MRCs, 30 or so ACRPs and are in the process of opening a 111 call handling centre. We have provided a state of the art vehicle maintenance facility, modern stores facility and a	We have sold 5 ambulance stations, 3 stations are awaiting completion of sale and 2 leases on stations have relinquished in the last 5 years		One re-location. The Trust is currently undertaking a review of all ambulance stations in the region.

East Midlands Ambulance Service	North East Ambulance Service	South East Coast Ambulance Services NHS Foundation Trust	West Midlands Ambulance Service	South Central Ambulance Services NHS Foundation Trust	North West Ambulance Service (NWAS) NHS Trust
		Hazardous Area Response Team (HART) base.			
If Ambulance Stations have been closed what have they been replaced with?					
The station in question has not been replaced as it was redundant.	New facilities in locations with enhanced operational coverage and / or with public sector collaborative working opportunities.	Ambulance stations will only be closed where it is clear that their mal-location impedes response times and some stations will be converted to ACRPs where they are located in the right place. Where we have closed ambulance stations we have opened more ACRPs than stations. ACRPs are aligned with patient demand and their locations reviewed annually.	Creation of make ready hubs		In temporary accommodation on same site, whilst new facility being built on same site, to be shared with Merseyside Fire Service.
Do your Ambulance Stations meet NHS standards of repair?					
Repairs are carried out to professional and NHS standards. All properties are compliant with the Health and Safety at Work Act (1974), associated Health Standards and the Factories Act (1961) requirements. However, we have established that roughly £12.5 million worth of work would need to be done to bring the Estates into line with the NHS Six Facet Appraisal Standards.	Yes. Planned maintenance is identified annually and station conditions reported via the annual ERIC Return.	All our facilities are subject to a cyclical conditioning survey in line with NHS Estate code.	Yes		There is no NHS “standard” of repair. Buildings are maintained and repairs are carried out on a priority basis. The level of these backlog repairs is monitored.
Do the Ambulance Stations act as a base for other Ambulance/ Transport services?					
Yes	Some do, but not all.	Patient Transport Services work out of some ambulance stations. The Hazardous Area Response Team covering the eastern part of our area work out of the Ashford MRC. Some ambulance stations provide Trust stores, IM&T and logistic support functions.	All our stations / hubs are either for our own ambulances or are shared with the fire service. We publish and regularly update when needed a full list of our property portfolios on our website.		No.
What is the protocol for 999 calls? Do you triage over the telephone?					
The questioning protocol used for 999 callers is called AMPDS and is widely used by Ambulance Services Worldwide. EMAS holds the	Yes – using NHS Pathways	When you ring 999 your call goes through to one of our three emergency dispatch centres (EDCs). Our trained emergency	Call received via 999 where demographic details, a contact number and a basic idea of the reason for call are taken.	Yes. All 999 and Health Care Professional calls are triaged using the DoH approved Advanced Medical Priority Despatch triage system. All	The system in use is called Advanced Medical Priority Dispatch System (AMPDS). An element of this includes telephone triage.

East Midlands Ambulance Service	North East Ambulance Service	South East Coast Ambulance Services NHS Foundation Trust	West Midlands Ambulance Service	South Central Ambulance Services NHS Foundation Trust	North West Ambulance Service (NWAS) NHS Trust
Accredited Centre of Excellence for both Control Room sites and has done so since 2006, the only Control Room to do so Worldwide. The Advanced Medical Priority Dispatch System (AMPDS) asks a series of clinically structured questions to identify the main patient complaint and then, through continued questions, can identify how critical or serious the call is and allocate a response priority in line with Department of Health criteria. We also use additional software called Telephone Assessment Software (TAS) which is used by our in-house Clinical Assessment Team (CAT) to further assist patients who may call 999 but do not need an ambulance and can be cared for through other NHS pathways. The CAT also provide further patient assessment to support delivery of patient care including, where necessary, welfare calls to patients.		call takers receive nearly 618,000 calls every year. We use a specialist computer system (used by all ambulance trusts) called NHS Pathways to determine the condition of the patient (this is known triaging a patient) so we can send the most appropriate response based on their clinical need. This might be an ambulance, or a single responder paramedic. Some patients who have minor ailments do not require an immediate emergency response or may not need an emergency response at all. We have clinically qualified staff in our EDCs who are able to take more details and provide further advice over the phone. If necessary they can make referrals to other community healthcare professionals such as GPs or community nurses, or to social care professionals, ensuring every patient always receives the most appropriate treatment for their need. See attached chart.	Call is then triaged using NHS Pathways which is a Nationally recognised software for the categorisation of 999 calls.	clinical triage is undertaking using the Briggs Telephone Triage Manual.	
Who is contracted to provide Community First Responders for the Service?					
St John's Ambulance, but there are independent groups	We currently only have one paid contract which is with Cleveland fire and rescue service, however we have various different MOU's with the below schemes (see 13) and other co-responders – i.e. Police, mountain rescue	We do not have anyone contracted to provide any part of our Community First Responders (CFR) production.	All of our Community First Responders (CFRs) are volunteers, there are no contracts.	None	The Trust does not have any such contracts with volunteers. It has a Memorandum of Understanding which is not a legally binding contract. CFRs are comprised of volunteers, BASIC Drs, St John Ambulance, Red Cross, Mountain Rescue.
How many Community First Responders do you have? Do you have any areas where there are no CFRs?					
We have a total of 1097 Community First Responders and just under 100 Medical First Responders (who are all employees of the East Midlands Ambulance Service NHS Trust). For further information, we can confirm that we have a total of 16	The Trust have 168 First Responders, they are spread across the trust area, however there are limited First Responders in the Tees and South Tyne Division.	We currently have 768 CFRs within SECAmb. There are some areas where there are no CFRs. We start schemes and set up Public Access Defibrillator sites in areas where there are high	Regionally we have 1395 CFRs in total, 1125 active and 270 in training.	We have a total of 1,500 volunteers across four counties.	NWAS currently has over 1,500 active CFRs, operating from more than 140 groups across North West communities. Yes – there are both rural and urban areas within the Trust that could be complemented by the development of CFRs.

East Midlands Ambulance Service	North East Ambulance Service	South East Coast Ambulance Services NHS Foundation Trust	West Midlands Ambulance Service	South Central Ambulance Services NHS Foundation Trust	North West Ambulance Service (NWAS) NHS Trust
Community First Responders in the Bassetlaw area of Nottinghamshire, operating as follows: • Retford 7 • Carlton–in–Lindrick 2 • Haworth 3 • North Leverton 1 • Clarborough 3 We do have good Community First Responder (CFR) coverage, but are always looking to expand this. We have currently identified 18 areas where we would like to establish new or expanded CFR schemes to improve coverage across the East Midlands.		volumes of calls within rural areas in particular and consequently the need changes on a regular basis. We use parliamentary wards, dispatch desks and Operational Dispatch Areas to identify areas of need and to inform our planning. For this financial year we have 150 parliamentary wards we are focussed on as these are deemed high priority.			
As part of your service do you deliver the Patient Transport Service/ transfers?					
Yes for North East Lincolnshire	Yes.	Yes	Yes in areas where the contract has been rewarded.	Yes	Yes - The PTS workforce comprises of 1,100 operational staff, supported by nearly 400 volunteer car service drivers,
If yes do you have a dedicated fleet of vehicles for this?					
Yes	Yes.	Yes	yes	Yes	Yes – We operate close to 500 PTS vehicles. Our dedicated fleet, which work across the North West, are able to deal with a multitude of patient conditions, from transporting stretcher and wheelchair bound patients to patients able to walk unaided.

7.3 Appendix 3 – Consultation response to EMAS

The Panel submitted a formal response to EMAS supported by the Overview and Scrutiny Committee. EMAS asked for supporting evidence which was also provided. The letters and information provided is below.

Mr P. Milligan
Chief Executive
East Midlands Ambulance Service NHS Trust
Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham NG8 6PY

Your ref:
Our ref: VC/SLM
Please ask for Mrs. Vanessa Cookson
Direct Line: (01909) 533733
E-Mail:
vanessa.cookson@bassetlaw.gov.uk

21st November 2012

Dear Mr Milligan,

As part of the scrutiny programme for 2012/2013 the Health Select Panel has been tasked to review 'The Ambulance Service in Bassetlaw.

The Chairman of the Health Panel presented their response to your consultation **'**Being the Best' to the Overview and Scrutiny Committee on Tuesday 20th November.

The Committee unanimously supports the Health Panel's response and the concerns highlighted. The Committee has therefore ratified the response attached and highly recommends that EMAS take note of the issues noted in the review, as part of future service design and developments.

As the response was discussed at a Public Meeting of the Council. It is now considered to be a public document and as such we are responding in advance of the consultation deadline.

The Health Panel will present their final report to the Committee in January and once it has been approved by Cabinet it will be released into the public domain. As a key partner in the review you will receive a copy of the report in due course.

Yours sincerely

J C Shephard

Councillor J. Shephard
Chairman of Overview & Scrutiny Committee

Mr P. Milligan
Chief Executive
East Midlands Ambulance Service
NHS Trust
Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham NG8 6PY

Your ref:
Our ref: VC/SLM
Please ask for Mrs. Vanessa Cookson
Direct Line: (01909) 533733
E-Mail: vanessa.cookson@bassetlaw.gov.uk

21st November 2012

Dear Mr Milligan,

'Being the Best' Consultation

On behalf of Bassetlaw District Council's Health Scrutiny Panel I would like to formally respond to your current consultation process. At this juncture the Panel is still agreeing the final content of its report on the Review of The Ambulance Service in Bassetlaw; however I hope that this response will convey our main concerns to you. Our final report will be available from February 2013 once it has been through our committee process. The points below summarise our main recommendations which will feature within our final report:

- In relation to your consultation exercise I can say that the Panel unanimously across the political spectrum have no confidence in the proposals put forward by EMAS. Based on all the evidence gathered as part of our Review process, the Panel also unanimously felt that the proposals do not benefit Bassetlaw residents. In light of the Panel's consideration we believe that EMAS should reconsider these proposals with immediate effect.

- Regarding the Ambulance Stations the Panel again unanimously agreed that the two Ambulance Stations in Bassetlaw should be retained in their current locations and refurbished to an acceptable standard.

- The Panel believe there should be no cuts in the current service provision. Where EMAS insist that resources need to be cut or re-aligned we expect a clear indication as to what alternative arrangements are in place, voluntary or otherwise, to cover the gaps left in resource provision.

- The Panel have been disappointed at the approach taken by EMAS to publicise the consultation process 'Being the Best' and the documents that have been used. We feel they are not accessible to the 'hard to reach' and the process has not been wide reaching in the range of responses sought. As an area with poor broadband access there will be a large number of residents that have not been able to respond electronically. We are also aware that there has been low circulation of hard copies by EMAS in the more rural communities. We feel there should also have been more communication with key partners in the District, particularly in relation to the open meetings directly arranged by EMAS in Worksop and Retford (9th October and 28th November) which we had limited notice of. We feel there has been too much reliance on the EMAS website as an information source for people.

- From the evidence gathered we feel that across the region there needs to be an improved approach to patient pathways and handover processes at the various hospitals served by EMAS. We are specifically aware of major issues in turnaround times at Bassetlaw District General and Doncaster Royal Infirmary Hospitals, which need to be rectified as soon as possible. We will also be making these concerns

known to Bassetlaw CCG and the Hospital Trust.

- The Panel is also concerned regarding the scheduled housing developments planned up to 2020, particularly in the Harworth/Bircotes area and other rural areas, which we feel EMAS may not have given enough consideration to. We ask that EMAS reconsiders its cross-border arrangements to ensure there are adequate resources in place, as we feel that there is currently not enough emphasis on this. Our evidence has shown that Yorkshire Ambulance Service could not provide additional support over and above what is currently in place as part of the national approach to cross-border arrangements

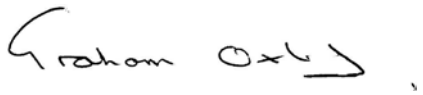
- Our own residents' survey completed as part of our review (to complete 1st December), shows that while there is general satisfaction with the service provided by EMAS, there are clear concerns about the proposals being consulted on.

The Panel have spent two full days listening to healthcare professionals, patients and patient representatives and have concluded that the EMAS proposals contained in the document 'Being the Best' will have a detrimental effect on Bassetlaw patients and will further reduce the quality of service in our area.

The overriding concern is that your proposals will put Bassetlaw residents at risk. EMAS is already failing the national response time targets. Clearly it is easier to achieve these national standards in urban areas. Our concern is that the poorer response times in a rural area like Bassetlaw will be masked by these results and that a failing service in Bassetlaw will be ignored.

There are genuine anxieties and fears in our community and it is on this basis, as part of our recommendations, that we strongly believe your proposals should be reconsidered.

Yours sincerely



Chairman of the Health Panel

Mr P. Milligan
Chief Executive
East Midlands Ambulance Service NHS Trust
Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham NG8 6PY

Your ref:
Our ref: VC/SLM
Please ask for Mrs. Vanessa Cookson
Direct Line: (01909) 533733
E-Mail: vanessa.cookson@bassetlaw.gov.uk

13th December 2012

Dear Mr Milligan,

'Being the Best' Consultation

Thank you for your letter requesting the evidence base for the Health Panel response to your consultation 'Being the Best'.

The attached table shows the evidence gathered and the logic used in relation to each of the seven points below. The supporting information is also included.

1. In relation to your consultation exercise I can say that the Panel unanimously across the political spectrum have no confidence in the proposals put forward by EMAS. Based on all the evidence gathered as part of our Review process, the Panel also unanimously felt that the proposals do not benefit Bassetlaw residents. In light of the Panel's consideration we believe that EMAS should reconsider these proposals with immediate effect.

2. Regarding the Ambulance Stations the Panel again unanimously agreed that the two Ambulance Stations in Bassetlaw should be retained in their current locations and refurbished to an acceptable standard.

3. The Panel believe there should be no cuts in the current service provision. Where EMAS insist that resources need to be cut or re-aligned we expect a clear indication as to what alternative arrangements are in place, voluntary or otherwise, to cover the gaps left in resource provision.

4. The Panel have been disappointed at the approach taken by EMAS to publicise the consultation process 'Being the Best' and the documents that have been used. We feel they are not accessible to the 'hard to reach' and the process has not been wide reaching in the range of responses sought. As an area with poor broadband access there will be a large number of residents that have not been able to respond electronically. We are also aware that there has been low circulation of hard copies by EMAS in the more rural communities. We feel there should also have been more communication with key partners in the District, particularly in relation to the open meetings directly arranged by EMAS in Worksop and Retford (9th October and 28th November) which we had limited notice of. We feel there has been too much reliance on the EMAS website as an information source for people.

5. From the evidence gathered we feel that across the region there needs to be an improved approach to patient pathways and handover processes at the various hospitals served by EMAS. We are specifically aware of major issues in turnaround times at Bassetlaw District General and Doncaster Royal Infirmary Hospitals, which need to be rectified as soon as possible. We will also be making these concerns known to Bassetlaw CCG and the Hospital Trust.

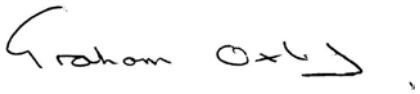
6. The Panel is also concerned regarding the scheduled housing developments planned up to 2020, particularly in the Harworth/Bircotes area and other rural areas, which we feel EMAS may not have given enough consideration to. We ask that EMAS reconsiders its cross-border arrangements to ensure there are adequate resources in place, as we feel that there is currently not enough emphasis on this. Our evidence has shown that Yorkshire Ambulance Service could not provide additional support over and above what is currently in place as part of the national approach to cross-border arrangements

7. Our own residents' survey completed as part of our review (to complete 3rd December), shows that while there is general satisfaction with the service provided by EMAS, there are clear concerns about the proposals being consulted on.

This is a brief overview of the evidence gathered and the final report will be a more detailed report this will be sent to you in due course.

If you require any further assistance please do not hesitate to contact the Policy Unit on 01909 533733.

Yours sincerely



Chairman of the Health Panel

7.4 Appendix 4 – Responding to your 999 Calls

The leaflet below was produced by EMAS and explains what happens when a 999 call comes into the control room.

East Midlands Ambulance Service NHS Trust

This leaflet has been produced by:
East Midlands Ambulance Service NHS Trust
Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham NG8 6PY

Tel: 0115 884 5000
Follow us on Twitter @EMASNHSTrust
Find out more about us at **www.emas.nhs.uk**

If you would like a copy of this leaflet in large print, audio or in another language, please call us on 0845 299 4112

This leaflet has been printed on recycled stock
design & concept by Fresh* Ad Communications t: 0116 2541351 e: alf@freshcom.co.uk

Responding to your 999 calls

Your at-a-glance guide

START →

CALL CATEGORY →

Your 999 call received
we assess the severity of the illness/injury and then allocate the call to either:

Category A – 'Red'

'RED 1'
Time Critical
Immediately life-threatening
E.g. Cardiac arrest

'RED 2'
All other Category A
Immediately life-threatening
E.g. Chest pain / Stroke

'Green'

'GREEN 1'
Serious clinical need
Serious but not life-threatening
E.g. Breathing problems / RTCs

'GREEN 2'
Less serious clinical need
Serious but not life-threatening
E.g. Fall / Haemorrhage

'GREEN 3'
Not an emergency
Not life-threatening
E.g. Sick / Unwell Abdominal pain

'GREEN 4'
Not an emergency
Not life-threatening
E.g. Sick / Unwell

Examples →

AMBULANCE SERVICE RESPONSE →

FACE-TO-FACE RESPONSE FROM AMBULANCE CLINICIAN

Fast response vehicle **OR** double crewed ambulance

Emergency blue light response

TELEPHONE ASSESSMENT

1 Upgrade to Red 1 or 2 Green 1 or 2

2 Refer to another souce of help
e.g. GP, District Nurse, Falls Team, Walk-in Centre, Pharmacy, Self Care

3 Advice given

PERFORMANCE SPEED (TME) →

Within 8 min	to arrive on-scene from receiving call in 75% of cases ('the A8 target')	Within 19 min	Double crew ambulance arrives (for patients who need transport) in 95% of cases ('the A19 target')	Within 20 min	from receiving call	Within 30 min	from receiving call	Within 20 min	from receiving call	Within 60 min	from receiving call

PERFORMANCE AND QUALITY OF CARE ↘

On 1 April 2011, the Department of Health introduced new national targets for ambulance services. The Category A life-threatening call target of responding to 75% of all cases within 8 minutes of the call being received was unchanged. However, 12 new Clinical Quality Indicators were introduced for non-life threatening calls. This means we are measured on how we treat patients and the outcomes of the treatment rather than just on timeliness. By monitoring performance in this way, we are able to identify good practice and any areas which need improvement. As an organisation keen to develop and improve, EMAS welcomed this change.

Examples of the new quality measures are:

- Outcome from cardiac arrest – survival to discharge rates
- Outcome following stroke
- Proportion of calls dealt with by telephone advice or managed without transport to A&E (where this is clinically appropriate)
- Unplanned re-contact from the patient within 24 hours of discharge of care (i.e. where patient not transported but has received telephone advice or treatment at the scene)

During the year, we improved our performance against a number of the standards and developed plans to target areas where further improvement was needed. This has enabled us to continually improve the quality care we deliver to our patients.

We publish our quality performance achievements every month on our website. The information provided also allows readers can see how well we're doing when compared to other ambulance services.

East Midlands Ambulance Service NHS Trust

Delivering quality patient care

A summary of our Quality Account
2012

RESPONSE

SUPPORT

TREATMENT

Introduction

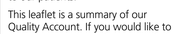
At East Midlands Ambulance Service (EMAS) the quality of care that we give to patients is our number one priority.

This leaflet, Our pledge to you, is for our patients and our public. I hope you will find it interesting and helpful. It gives you more information about the quality of our care. This includes the steps we have taken to improve quality and what we plan to do next.

Our pledge to you is our Quality Account – something produced each year by every NHS organisation that provides care to the public. I am very grateful to the members of the public, Local Involvement Networks (LINKs), EMAS Trust members and Health Scrutiny Committees who have helped us with our work on the Quality Account over the last couple of years – improving quality is an important and continuous process.

I also want to thank colleagues in all parts of EMAS, especially our clinicians, for their dedication and skill in delivering high quality care to our patients.

This leaflet is a summary of our Quality Account. If you would like to read more, please visit our website to view the full document which includes some interesting case studies about the experiences of patients – go to **www.emas.nhs.uk**



Phil Milligan
Chief Executive

Last year

April to March
2011-2012

We published a set of five priorities for improving quality at EMAS. They are shown below with details of what we did about them.

▼ QUALITY MEASURE	▼ PRIORITY
Patient Safety	**Priority 1:** Communication and Joint Working **Priority 2:** Developing our workforce
Clinical effectiveness	**Priority 3:** Effectiveness of treatment (Clinical Performance Indicators - CPI) **Priority 4:** Response to our patients (Accident and Emergency - A&E)
Patient experience	**Priority 5:** Treating patients with dignity, respect, care and compassion

Priority 1: Communication and Joint Working

What you told us:

You told us that we needed better communication when we handed care over to others – for example at hospital emergency departments.

What we did:

We have introduced a new way of working which covers four key elements when we communicate with other healthcare professionals. These are Situation, Background, Assessment and Recommendation (SBAR). This has made for better and safer handovers of care.

We also use SBAR if we handover patient care from one member of our own staff to another.

What else have we done?

We have put a lot of energy into cleaning our vehicles and premises to minimise any risks of infection. We check what we do regularly to ensure that we get this right (monitor and audit), and we meet the high standards set by outside agencies.

We have also worked hard to help those people we meet who are vulnerable. We have developed polices and procedures to safeguard vulnerable adults and children. We put these into practice when we deliver care to our patients and we have seen a significant increase in the number of 'at risk' patients we identify and access support for from health and/or social care partners.

Our work with people who have a learning disability has been recognised both nationally and regionally by the Department of Health.

Priority 2: Developing Our Workforce

What you told us:

You said that you would like to see more clinicians employed by EMAS.

What we did:

We increased our paramedic numbers by 29 to ensure that our patients receive high quality care from skilled and competent clinicians.

What else have we done?

With the support of the NHS primary care trusts who fund us, we have improved our staff cover levels – this reduces the impact of planned absences (for example, for training and education) and unplanned absences (for example, sickness absence) on the care we provide.

We have achieved a 60:40 ratio of paramedics to ambulance technicians/care assistants.

Our essential education programme for all staff took patient safety as its key theme.

The second year of our framework for clinical supervision and observed practice helped our frontline care staff to meet essential standards of quality and safety.

Priority 3: Effectiveness of treatment

(Clinical Performance Indicators - CPI)

What you told us:

You want us to treat you effectively when you call us.

What we did:

In March 2011 a new way of measuring how ambulance services work was introduced by the Department of Health.
These measurements are called Clinical Quality Indicators. They relate to how we treat patients and the outcomes of that treatment.

Over the year we improved our performance against each of these indicators. We also took action where further improvement was needed. Each month we outline the progress we are making on our website so you can see how we are doing.

Priority 4: Response to our patients

(Accident and Emergency - A&E)

What you told us:

You want us to meet the national performance targets for speed of response when you dial 999.

What we did:

We achieved only one of our two targets for 999 response times to patients, although we improved our performance in both.

We met the A8 national target for life threatening emergencies, recording 75.2% (national target 75% in 8 minutes over a full year; our result is up from the previous year's 72.4%). We did not meet the A19 national target for life threatening emergencies, recording 92.3%, (national target 95% in 19 minutes over a full year; our result was up from the previous year's 88.3%).

What else have we done?

We have laid foundations to make improvements in our speed of response so that we can meet and work to exceed the national targets consistently. We have introduced new staffing rotas to more closely match staff availability to the 'demand patterns' of the 999 calls that we receive. We have introduced a new telephone system that makes our 999 call answering faster. And we have added more staff, all with training and experience in caring for patients, to our Clinical Assessment Team in our 999 call centre – this helps to ensure that we provide the most appropriate response to the needs of individual patients.

Priority 5: Treating patients with dignity, respect, care and compassion

What you told us:

You told us that the way we treat patients and family and friends was important.

What we did:

Many patients and members of the public expressed appreciation for the way our clinical staff treat people in what are often stressful situations. Sometimes we do not get this right, resulting in complaints from which we are able to learn valuable lessons.

We have enthusiastically joined a national patient dignity campaign and have quickly built up to over 400 'Dignity Champions' who support and promote to others best practice in the way we treat our patients.

We have developed our services for people with learning disabilities and increased the number of staff attending training in how best to meet people's needs. This includes taking account of family relationships. By going out to meet with communities and groups and engage with service users and carers we have identified ways to make our service more accessible to all and we have put this into practice.

We asked our Foundation Trust members to describe in one word how they view EMAS. The following shows what they said – the size of each word is in proportion to the number of times members used it.

This year

April to March
2012-2013

We are going to drive forward our work on improving quality to enhance patient safety, patient experience and the clinical outcomes for patients.

Our priorities have been developed with our staff, service users and the public and are shown below:

Patient safety	**Priority 1:** Improvements based on what staff told us in our annual staff opinion survey and their annual appraisals.
Clinical effectiveness	**Priority 2:** Continue to improve our processes for the way we handle 999 calls, make clinical assessments and use our ambulances and clinicians. **Priority 3:** Improve the existing clinical performance indicators and develop new ones.
Patient experience	**Priority 4:** Continue to engage with people and groups so that patient experience influences the way we develop and improve our service. **Priority 5:** Develop a training package linked to a new Domestic Violence Policy so frontline staff can recognise and deal effectively with victims and perpetrators of Domestic Violence.

We are going to check how we do against these priorities over the course of the year. We will do this formally through a sub-committee of the EMAS Trust Board. We will also take a mid-year Quality Account report to the Trust Board.

You can follow this through our website www.emas.nhs.uk/trustboard In this way you can see that EMAS is committed to improving the quality of the care we provide to you, and that we are honest and open with you about how we do this.

7.5 Appendix 5 – Divisional and District Performance

The tables below provide a snapshot of performance in the two national targets across the EMAS region and broken down into divisions and counties.

Table 5: Divisional and County Performance in A8 & A19 Sept 2012

MONTH: Sep 2012	Performance	
	CAT A8	CAT A19
Derby City PCT	89.68%	98.29%
Derbyshire County PCT	69.31%	93.88%
DERBYSHIRE DIVISION	76.14%	95.36%
Leicester City Teaching PCT	87.15%	98.26%
Leicestershire County PCT	69.61%	94.96%
LEICESTERSHIRE DIVISION	77.65%	96.47%
Lincolnshire Teaching PCT	69.79%	84.70%
North East Lincolnshire PCT	87.33%	96.45%
North Lincolnshire PCT	78.57%	95.35%
LINCOLNSHIRE DIVISION	73.89%	88.16%
Northamptonshire Teaching PCT	77.32%	95.80%
NORTHAMPTONSHIRE DIVISION	77.32%	95.80%
Bassetlaw PCT	67.47%	92.53%
Nottingham City PCT	83.96%	97.82%
Nottinghamshire County PCT	68.80%	95.92%
NOTTINGHAMSHIRE DIVISION	74.84%	96.38%
EMAS	75.70%	94.14%

YTD: Apr 2012 to Sep 2012	Performance	
	CAT A8	CAT A19
Derby City PCT	91.24%	98.65%
Derbyshire County PCT	66.37%	94.23%
DERBYSHIRE DIVISION	74.35%	95.64%
Leicester City Teaching PCT	88.95%	98.97%
Leicestershire County PCT	71.40%	95.01%
LEICESTERSHIRE DIVISION	79.22%	96.77%
Lincolnshire Teaching PCT	71.03%	86.58%
North East Lincolnshire PCT	87.55%	97.56%
North Lincolnshire PCT	79.25%	94.84%
LINCOLNSHIRE DIVISION	74.88%	89.53%
Northamptonshire Teaching PCT	73.66%	94.60%
NORTHAMPTONSHIRE DIVISION	73.66%	94.60%
Bassetlaw PCT	68.57%	93.64%
Nottingham City PCT	82.89%	98.42%
Nottinghamshire County PCT	68.43%	95.93%
NOTTINGHAMSHIRE DIVISION	74.02%	96.68%
EMAS	75.23%	94.51%

The table below shows the response times across all of the categories over the last five years.

Table 6: Bassetlaw Annual Performance

Bassetlaw Performance	A8%	A8 RESPS	A19%	A19 RESPS	B19%	B19 RESPS	C240%	C240 RESPS	GREEN1 20 MINS	G1 RESPS	GREEN2 30 MINS	G2 RESPS
2008/09	70.35%	3909	95.37%	3909	93.42%	5429	100.00%	1538				
2009/10	71.47%	4266	95.59%	4266	94.42%	5647	100.00%	1858				
2010/11	68.03%	4951	93.32%	4943	87.34%	5626	99.86%	2105				
2011/12	71.47%	5030	92.26%	5025					86.27%	714	89.02%	3624
2012-13	68.57%	2297	93.64%	2294					82.75%	539	83.20%	2190

No figures are available for G3 & G4, at this level. 2012-13 is up to and including September 2012.

The tables below break down the A8 response times into the two Red categories as defined in Section 4.1.2

Table 7: District performance

A8 Red 1	Apr 12	May 12	June 12	July 12	Aug 12	Sept 12	Oct 12	2012/13 Total
NHS Bassetlaw	71.8%	76.2%	83.7%	62.0%	48.8%	69.6%	53.0%	66.4%
EMAS	80.7%	77.5%	77.6%	70.6%	70.2%	70.7%	71.0%	74.0%

A8 Red 2	Apr 12	May 12	June 12	July 12	Aug 12	Sept 12	Oct 12	2012/13 Total
NHS Bassetlaw	67.4%	69.6%	70.2%	68.0%	67.8%	67.2%	65.0%	67.8%
EMAS	74.9%	73.2%	75.3%	75.6%	76.1%	76.2%	75.2%	75.2%

7.6 Appendix 6 – Turnaround information

This information shows the handover and turnaround times of crews in Retford and Worksop Stations. This shows that both parties are failing the targets for handover.

Station Handover and Turnaround Times
Business Intelligence Unit

East Midlands Ambulance Service NHS Trust

April

Station	Pre Handover	Post Handover	Turnaround
RETFORD STN	00:17:52	00:16:54	00:35:00
WORKSOP STN	00:15:23	00:13:00	00:28:28

May

Station	Pre Handover	Post Handover	Turnaround
RETFORD STN	00:15:38	00:17:01	00:32:35
WORKSOP STN	00:15:03	00:13:21	00:28:31

June

Station	Pre Handover	Post Handover	Turnaround
RETFORD STN	00:17:34	00:17:12	00:34:58
WORKSOP STN	00:16:26	00:12:58	00:29:23

July

Station	Pre Handover	Post Handover	Turnaround
RETFORD STN	00:18:20	00:17:52	00:36:21
WORKSOP STN	00:16:22	00:13:48	00:30:19

August

Station	Pre Handover	Post Handover	Turnaround
RETFORD STN	00:15:56	00:17:42	00:33:17
WORKSOP STN	00:16:15	00:14:33	00:30:58

September

Station	Pre Handover	Post Handover	Turnaround
RETFORD STN	00:17:23	00:15:04	00:32:28
WORKSOP STN	00:16:10	00:13:44	00:30:10

YTD (01/04/2012 to 30/09/2012)

Station	Pre Handover	Post Handover	Turnaround
RETFORD STN	00:17:06	00:16:44	00:33:53
WORKSOP STN	00:15:54	00:13:17	00:29:19

7.7 Appendix 7 – Planning Policy Information Request (Future Housing Supply)

The following information indicates the expected population change within the district if housing supply is increased as projected.

Future committed developments (after 5 years)

- Worksop
  - 417 houses have already been earmarked
  - This would equate to 959 people (based on 417 x 2.3).

- Retford
  - 1056 houses have already been earmarked
  - This would equate to 2429 people

- Harworth Bircotes
  - 264 houses have already been earmarked (could include the second phase of the colliery development, which has planning permission for 855 further dwellings – has planning permission for 15 years, no indication of start date though)
  - This would equate to 607 people

- Tuxford
  - 42 houses have already been earmarked
  - This would equate to 97 people

- Misterton
  - 139 houses have already been earmarked
  - This would equate to 320 people

- Carlton in Lindrick/Langold
  - 314 houses have already been earmarked
  - This would equate to 722 people

- Rural villages
  - 134 houses will be allocated across the district, across 20 villages
  - This would equate to 308 people

Future developments – based on allocations (after 5 years)

- Worksop
    - A further 670 houses will be allocated
    - This would equate to 1541 people

- Retford
    - A further 289 houses will be allocated
    - This would equate to 665 people

- Harworth Bircotes
    - A further 359 houses will be allocated
    - This would equate to 826 people

- Tuxford
    - A further 63 houses will be allocated
    - This would equate to 145 people

7.8 Appendix 8 – Broadband Coverage

The Map below shows broadband coverage in the district and highlights how some rural areas have no or very slow broadband connections.