TO: HEALTH OVERVIEW AND SCRUTINY PANEL
11 JULY 2013

SOUTH CENTRAL AMBULANCE SERVICE
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report invites the Health Overview and Scrutiny (O&S) Panel to receive updates on the South Central Ambulance Service NHS Foundation Trust's performance on two issues identified by the Panel as being of interest and concern.

2 RECOMMENDATION

That the Health Overview and Scrutiny Panel:

2.1 Reviews the South Central Ambulance Service's performance on

- **Out-of-hospital cardiac arrest survival rates; and**
- **Ambulance response times.**

3 SUPPORTING INFORMATION

3.1 The Health O&S Panel last reviewed the position on out-of-hospital cardiac arrest survival rates at its meeting on 27 September 2012, and decided to review progress six months later. The relevant extract from the minutes of that meeting are at Appendix 1.

3.2 Following concerns reported in the national press that South Central Ambulance emergency response times had fallen below target, the Panel Chairman decided that this opportunity should also be taken to review the position on response times.

3.3 South Central Ambulance Service's most recently published 'Integrated Performance Report' for the period ending April 2013 covers both these aspects of performance and is attached at Appendix 2. The principal pages are 2, 7 and 9, but the complete report is attached as other pages refer to factors bearing on response times.

ALTERNATIVE OPTIONS CONSIDERED/ ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS/ EQUALITIES IMPACT ASSESSMENT/ STRATEGIC RISK MANAGEMENT ISSUES / OTHER OFFICERS/ CONSULTATION – Not applicable

Contact for further information

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Appendix 1

HEALTH OVERVIEW AND SCRUTINY PANEL
27 SEPTEMBER 2012

Cardiac Arrest Survival Rates

John Black, Medical Director of the South Central Ambulance Service (SCAS), and Steve West, Operations Director North attended the meeting to comment on the Trust's performance on out-of-hospital cardiac arrest survival rates.

Data collection for the SCAS in the South East had been more recent than data collection in London and was expected to improve in the future. One in three patients were taken to hospital with a pulse after a cardiac arrest, which was an improvement on the earlier position. Survival rates in relation to out-of-hospital cardiac arrests were expected to be better in the South East when compared to other regions of the country.

There was a focus on achieving best clinical outcomes and all ambulance crews had received refresher training on new devices and clinical systems. The aim was to despatch ambulances more quickly and community responder teams were being developed. Work was being undertaken with sports teams and there was close working with clinical colleagues. Quality of care in hospitals and direct access to cardiac care was important.

There were challenges regarding information sharing, and there was an indicator for the whole health system in relation to discharges. There was an aim to have an emergency care team at SCAS to assist in improving survival rates for patients.

In response to Members' questions, the following points were made:
• Ambulance services were required by national standards to respond to calls in 8 minutes, and the SCAS responded to 78% of calls in 8 minutes.
• Questions asked from the control room at SCAS did not delay the despatch of an ambulance. The location of a call was confirmed at the same time as questions were asked. Around 95% of calls were answered within 10 seconds and maximum response times were also monitored. SCAS was a national leader in ambulance response times. The control room could advise members of the public or relatives who were with a person who had a cardiac arrest on how to deal with the situation; initial actions by people did help.
• There had been approximately a 6% increase in the number of calls to the call centres which had been amalgamated into one main call centre, and an 8% increase in calls in Berkshire. This had started in February 2012 and was mainly occurring in the evenings and on weekends, and was putting pressure on resources.
• The transfer of staff from Wokingham to Bicester had been seamless and there was now an increased number of staff. Previous call handling had not been as quick but work was being undertaken to improve this and the team of call handlers had been increased to twenty people. Calls were now being answered in approximately 10 seconds. Some staff were redeployed to places other than Bicester. There was a knowledge gap once the merger of call centres had been undertaken and performance had been challenged over the summer months but this had improved now and staff were responding well to the change.
• Capability to progress calls for urgent cases or people requiring community care was being addressed.
• London was a different area to the South East and there was rapid access to defibrillators in many locations in London which made a difference to cardiac arrest survival rates.
• Better quality data was expected in future; just two months of reliable data had been received from hospitals and the way percentages were calculated could make survival rate data look inflated.

• Training was offered to members of the public who wanted to be community responders and ambulance control rooms could instruct people on how to use defibrillators. Signposting to these kits was also important and tracking the location of semi-automatic defibrillators.
• SCAS worked with some 1,400 volunteer Community Responders, and training was refreshed every three months. Anyone interested in becoming a community responder should contact SCAS and they would be put in contact with a local community responder team. Community responder teams were funded by different means including the local community, British Heart Foundation, and public funding. A link would possibly be made with Parish Councils.
• Data was collected using a paper based system which paramedics handed over to hospital staff on arrival to hospital with a patient. Care pathways were well developed and hospital staff used data from electronic systems. The aimwas for there to be electronic links to enable data to be sought directly from hospitals.
• The Department of Health published in May the information from the data collected in relation to cardiac arrest survival rates and this could be shared with members of the Panel.
• There were eleven Ambulance Trusts nationally and clinical indicators were being developed. The aim was to identify good practice and share it.
• There was a national digital system called ‘Airwave’. The next system of digital radio was being jointly procured by the Fire, Police and Ambulance Services.
• Mr Black thanked Bracknell Forest Council for its support towards, for example, the Chiltern Air Ambulance Service.

The Chairman thanked Mr Black and Mr West for appearing before the Panel, and indicated that the Panel may wish to review progress on cardiac arrest survival rates in around six months time.