



Foreword

The ambulance service in the West Midlands is an important health resource for the local population. For many people, the service is the first point of access to health care, responding to a variety of needs, from life-threatening emergencies to long term health conditions. For over eight hundred thousand people each year who dial 999, the ambulance service in the West Midlands is the first, and often the most important contact.

Demand on the ambulance service is increasing every year, and we are currently seeing calls for emergency ambulances at the highest level ever in the West Midlands. This has resulted in the service operating under extreme pressure in some parts of the Region.

During the last two years, local commissioners have funded an additional £20 million to enable the ambulance service to respond to increasing demand. During this time, more than 170 extra paramedics have been recruited across the West Midlands, with additional vehicles and support staff.

The NHS now spends £142 million on emergency ambulance services across the West Midlands. The current demand however is continuing to grow at an unprecedented rate, and additional investment is not keeping pace with demand, despite the West Midlands being one of the most cost effective services in the country.

Whilst most people are familiar with the role of the ambulance service in emergency situations such as heart attacks and car accidents, increasingly, the service is being developed as a mobile health resource for the whole of the NHS.

Trained staff are developing their roles, and the number of highly skilled paramedics is increasing. Over time, more and more people who dial 999 for an emergency ambulance are able to be treated at home, and a visit to hospital avoided.

We are keen to ensure that the people of the West Midlands receive care of the highest standard. In the event of an emergency, people need to be assured that the ambulance service will deal appropriately with their needs.

We are committed to providing a comprehensive emergency ambulance service. We need to have a better understanding of the emergency care needs of our population, and the resources that can best meet this need. With increasing demand, and changing opportunities, we have commissioned an independent review of the emergency ambulance service in the West Midlands.

The review was tasked with looking at how the service operates and is funded, and to make recommendations on the future. The review has been undertaken with the support and co-operation of all health partners across the West Midlands.

We recognise ambulance staff work extremely hard under demanding and difficult circumstances. Their hard work, dedication and commitment, has ensured that people in the West Midlands receive a good service, and we look forward to building on the findings of the review to establish a stronger and more resilient ambulance service.

The review is now complete, and we are pleased to present this to you.

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Efficiency Review

of

The West Midlands Ambulance Service NHS Trust

Undertaken by Lightfoot Solutions

in association with

Lis Nixon Associates

on behalf of

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1. Executive Summary

This report is the result of a project commissioned by the West Midlands Specialised Commissioning Team (WMSCT) on behalf of the 17 West Midlands Primary Care Trusts (PCTs) to assess the ability of the West Midlands Ambulance Service (WMAS) to meet the ambulance performance standards across all the PCT areas in the West Midlands; the cost effectiveness of the service; the capability of WMAS to meet the requirements of the 'Ambulance Commissioning Model of Care'; and the most appropriate way to share ambulance contract costs across the different PCTs

In Section 3 of the report we outline the model that we have used to analyse the resource requirements that would be required by WMAS to enable the Trust to met the category a 8 minute standard across the West Midlands area while at the same time delivering an equitable standard of performance against the Category A 8 minute standard in each PCT area as well as meeting the Category A and Category B 19 minute standard in each PCT area. We also outline the key factors that need to be taken into account in determining the amount of resource that is required to provide this level of performance and the associated level of resource and funding that is implied for the PCTs.

In Section 4 we set out the findings of our analysis of the efficiency and effectiveness of WMAS and our assessment of the additional resource and funding that WMAS will need if it is to meet all its key performance targets.

Section 5 of the report sets out our conclusions and our recommendations in relation to the actions that we believe are required by WMAS and other key stakeholders to resolve the immediate performance issues and to develop the Trust in a way that will provide a service that compares favourably with other similar trusts.

The principal findings from our analysis are as follows.

- Based on current ways of working, WMAS will require a considerable number of additional staff to meet national targets, particularly in the more urban areas of the Region. We would propose a review of innovative approaches to delivering front line provision of urgent care, alongside a review of the workforce requirements.
- In the medium to longer term, we would propose a review of innovative approaches to delivering front line provision of urgent care, alongside a review of the workforce requirements and training.
- The current arrangements for clinical oversight and governance at WMAS could be improved by involving representatives from the rest of the urgent care network in the West Midlands.



- WMAS and PCTs should work in partnership to agree on an appropriate level of funding to ensure national response standards are met.
- The current response model in WMAS relies on Technicians and Emergency Care Assistants (ECAs). To improve access to alternative care pathways it is recommended that a review of paramedic workforce requirements is undertaken.
- The current funding arrangements largely reflect the population base of the PCTs and do not reflect the current level and growth of EMS activity across the West Midlands health economy. A new model of response and funding is required that distinguishes between the requirements of the highly urban areas and the more rural parts of the health economy.
- Since the creation of WMAS there has been a focus by WMAS and Commissioners on achieving short term performance at the expense of developing strategic direction
- WMAS operates on the basis of the four legacy organisations and in some areas has still to develop a common operational approach across the Trust
- The management structure at WMAS is lean and depends heavily on a limited number of key executives and middle managers
- WMAS and the PCT Commissioners need to establish a more sophisticated mechanism for analysing the patterns of demand for EMS services and for identifying the factors underlying changes in activity
- WMAS needs to ensure that the management information collected is used to identify emerging trends in its performance and lacks a trust wide performance management structure to manage and monitor the introduction of new operational processes
- There is scope for reducing the rate of ambulance attendance and transportation particularly in relation to Category B and Category C incidents through the use of new and innovative ways of responding
- There are areas of good practice within the four legacy Localities of WMAS but mechanisms need to be established to ensure these are shared and implemented across the whole Trust where appropriate



2. Background to the review

2.1. Introduction

The West Midlands Ambulance Service (WMAS) is commissioned by the West Midlands Specialised Commissioning Team (MSCT) to provide Emergency and Urgent Ambulance and associated services on behalf of the 17West Midlands Primary Care Trusts (PCTs). The contract with WMAS is worth in excess of £142m, although WMAS have for some time expressed concern regarding this funding level.

WMAS has been delivering performance that has, regionally, exceeded National Standards for the last 3 years. However, a decline in performance commenced in May 2008 and resulted in a reduction in response times that, by December 2008, challenged achievement of national targets by WMAS. This was against a picture of gradually and then rapidly increasing operational activity.

Extra financial resources were made available to WMAS in 2008/9 by all the West Midlands PCT's and the WMSHA to address the immediate issues. The intent of this funding was to try to halt and reverse the falling performance standards by incentivising staff to work overtime. However this was recognised by both WMAS and the PCTs to be only a temporary solution and it was acknowledged that a longer term solution was required that would involve additional funding from the PCTs for WMAS.

However, the PCTs were concerned at the reduction in performance at WMAS. There were also concerns that WMAS regularly underperforms in the more rural PCT areas despite the fact that extra financial resources had been provided by individual PCT's to try and improve performance in their local areas. The PCTs felt that there was a lack of clarity regarding the appropriate cost of emergency and urgent ambulance service provision for the West Midlands. This lack of clarity was exacerbated by concern around the cost effectiveness of the ambulance service model deployed by WMAS. At the same time, WMAS pointed out that is was operating with one of the lowest reference costs among the English ambulance trusts.

WMAS and PCTs jointly agreed to an independent review to examine the following issues:

- WMAS current ability to meet ambulance performance standards across all West Midlands PCT's within current contracted income levels
- The cost effectiveness of the current service
- WMAS ability to meet ambulance performance standards across all West Midlands PCT's and meet the requirements of the 'Ambulance Commissioning Model of Care' and action needed to accomplish this
- The most appropriate way to share ambulance contract costs across the West Midlands



2.2. The Emergency Medical Service (EMS) in the West Midlands

WMAS is the third largest ambulance service in the UK. It covers a population of 5.3 million people

WMAS was created in July 2006 from the merger of three ambulance trusts in the West Midlands, Coventry and Warwickshire and Herefordshire and Worcestershire. At the time of the original merger in 2006 the Staffordshire Ambulance Service remained as a separate organisation, but was subsequently also incorporated into WMAS in October 2007

In 2008/9 WMAS received an average of 14,000 999 emergency calls per week and responded to an average of 12,600 emergency incidents together with 1,500 urgent and routine incidents per week.

The breakdown of Emergency activity and performance in 2008/9 is set out in Table 1. This shows that there were significant differences in the proportion of activity that was categorised as Category A or Category B and also in performance levels between the different operating areas of the Trust

| | Percentage of Category A incidents | Percentage of Category B incidents | Percentage of Category C incidents | Category A 8 minute performance | Category A 19 minute performance | Category B 19 minute performance |
|--|--|--|--|---------------------------------------|--|--|
| Birmingham and the Black Country | 33 | 45 | 22 | 73.2 | 98.9 | 95.0 |
| Staffordshire | 33 | 44 | 23 | 78.5 | 98.7 | 97.7 |
| Coventry and Warwickshire | 24 | 50 | 26 | 76.5 | 98.2 | 95.4 |
| Herefordshire Shropshire and Worcestershire | 31 | 47 | 22 | 72.2 | 95.6 | 94.4 |
| WMAS | 31 | 46 | 23 | 75.4 | 98 | 95.4 |

Table 1 EMS activity levels and performance by Division in 2008/9

However, as is shown in Chart 1, WMAS Category A performance has shown a downward trend from the beginning of 2008/9. The position stabilised during two periods (Sep-Oct 08, and Jan-Feb 09), when performance reached above 75%, but from late April 2009, performance has fallen below the required 75%.





Chart 1: SPC chart showing the downward trend in Category A performance

The report assesses the factors underlying the performance problems at WMAS and suggests how the EMS service might be reorganised in the context of the urgent care services across the West Midlands health economy in a way that delivers a more effective and efficient service to patients.

2.3. Structure of the review

The review consisted of the following three complementary work streams:

- 1. An analysis of the demand profile to which WMAS is required to respond together with a review of the deployment strategy and rota structure by comparison with best practice in other ambulance trusts to assess the extent to which performance could be improved by enhanced operating procedures and the extent to which additional resource might be required in order to meet the performance standards. The reference period for this analysis was a 13 week period from 29 December 2008 to 29 March 2009
- 2. A review based on structured interviews of the effectiveness of WMAS's processes and systems, and current operational and clinical procedures together with a review of the current commissioning practices.
- 3. An analysis undertaken by Deloittes of the fully loaded costs that WMAS incurs in providing the EMS service in order to establish the basis on which any increase in front line resource that was identified should be charged back to the PCTs



3. The response and PCT funding model

The approach that has been adopted in undertaking the analysis in this report is based on a model of ambulance response which enables both the Ambulance Trust and the Commissioners to determine the amount of front line resource that is required to achieve a given level of performance within any PCT area and the costs that are associated with that level of resource.

3.1. Establishing equitable standards across the health economy

A key consideration when determining the most appropriate way for an ambulance service to meet its performance targets is the need to establish equitable standards of response across the whole community whilst at the same time recognising the implications of the standards that are agreed in terms of both practicability and cost effectiveness.

The overarching consideration in determining the achievability of the performance targets is the way in which geography, demography, transport, road and health infrastructures influence the amount of resource that is required to achieve the target in question. This is materially different when considering the response to the Category A 8 minute target and the Category A and Category B 19 minute standard.

3.1.1. Response areas and achievable response standards for the Category A 8 minute standard

The primary purpose of the Category A 8 minute target is to provide lifesaving services to a patient who has suffered a heart attack within a timeframe that carries a reasonable chance of resuscitation. In this context the response can consist of any suitably trained person who has access to a defibrillator which they have been trained to use and does not have to consist of a vehicle capable of transporting the patient.

In order to meet this standard, a trust has to plan with a high level of certainty to have a suitable level of response resource available that is capable of attending these life threatening incidents within the time that is allowed for the response. The amount of resource that is required to deliver this standard of response is determined by the likely location of the incident and the amount of time that the responder has available to travel to the incident.

The time that is available for the responder to travel to the scene of the incident is the time that remains within the 8 minute response window once

- the response vehicle has been identified by the dispatch centre
- the responder has been notified of the incident and



• the responder is in the response vehicle and beginning to travel to the scene of the incident.

The implication of this is that it is only possible to reach a Category A incident within the 8 minute window where there is a response resource that is already available and positioned within a 6 minute drive time of the incident at the time that the 999 call is received. Consequently in determining the amount of resource that is required to meet the standard it is necessary to identify the locations where Category A incidents are most likely to occur and to plan the deployment of the trust's response resource within those areas.

A typical area that could be covered within a 6 minute drive time is shown in Figure 1 below. By identifying those areas where Category A incidents are most likely to occur it is then possible to identify the optimal location of response vehicles within 6 minute deployment areas to maximise the likelihood that the incident will receive a response within the 8 minute response window. Where adequate resource is available and it is deployed in this way, a high level of Category A performance can be achieved – in some cases in excess of 85%.





However, it is clear that this approach to deployment, which requires the provision of a dedicated response resource which is fully funded by the ambulance trust, will only be cost effective in those more densely populated areas where there is a sufficiently high level of activity to ensure that the response vehicle undertakes a reasonable level of activity.



Typically urban area activity of this type, where there is a high probablility of 2 or more category A incidents occurring in any 24 hour period within a deployment area, accounts for between 70% and 80% of the activity within the area of an ambulance trust. This leaves between 20% and 30% of the Category A incidents where an alternative model is required for the provision of initial response.

The areas outside the more densely populated urban areas fall into three groupings as follows

- Mid sized market towns where there is a predictable level of daily activity, but there are less than 2 Category A incidents on average per day
- Smaller towns and large village communities where there is occasional activity but there is less than 1 Category A incident on average per day and
- Sparsely populated rural areas where activity is widely spread and there are no material concentrations of population

In the mid sized market towns, it is not realistic or cost effective for the ambulance trust to provide a dedicated resource solely to respond to Category A incidents within the 8 minute response window. However, it is possible for the ambulance trust to establish a retained (paid for) response scheme in collaboration with the local health community and possibly also involving the Fire and Rescue Service and the Police which can provide an appropriate level of initial response for that community. In these cases it is realistic to expect that an initial response provided by a scheme of this type will meet or exceed the 75% Category A standard.

In the smaller towns and larger villages, it is more difficult for an ambulance trust to provide an assurance of a suitable level of initial response without the involvement of volunteer responders. In many parts of the United Kingdom there are a large number of communities of this type which are more than a 6 minute drive from the nearest town and where typically there will be at most one or two Category A incidents per week. The only practical way of providing an initial response in these areas within the 8 minute window is through a voluntary Community Responder scheme. Where such schemes exist they can provide a high level of initial response to their local community, but the development of schemes of this type is time consuming and requires a high level of commitment from the local community. It should be recognised, however, that although the community responders are volunteers, the infrastructure necessary to support, manage and deploy community responders has its own cost that has to be borne by the ambulance trust.

In the sparsely populated areas, which are outside the reach of a community response scheme, it is unrealistic for an ambulance trust to plan to achieve any sustained level of Category A 8 minute performance and in general ambulance trusts find it difficult to achieve levels of Category A performance above 40 - 50% outside the urban areas and the larger market towns.



3.1.2. Response standards and resource requirements to meet the Category A and Category B 19 minute standards

Unlike the case with the Category A 8 minute target it is possible to develop a deployment strategy that will ensure that all areas within an ambulance trust are provided with a response by a fully equipped emergency vehicle within the 19 minute standard. In order to be able to meet this standard, however, the trust requires sufficient transportation resource to be able to respond not only to the normal daily levels of activity, but also to peak levels of activity and to provide the required level of cover and transporting capacity across all the geographic regions. The factors that determine the amount of resource that is required to meet this standard are

- The predicted average and peak level of activity at each hour for each day of the week
- The volume of activity and the geographic area that can be covered by an ambulance operating in more rural areas
- The percentage of incidents that require transportation to hospital
- The length of time that it takes an ambulance to complete a job, including in particular
 - o the time taken to reach the hospital
 - \circ $\;$ the time taken to return from hospital and
 - o the time taken to hand over the patient to the care of the hospital staff.

In calculating this resource requirement it is also important to recognise that the same double staffed ambulance resource is also required to meet the performance standards for Urgent incidents as well as responding to Category C incidents and Hospital Transfers. In this context, ambulance trusts are examining options for providing transport to hospital in cases where the patient's condition does not require them to be accompanied by a Paramedic or in a double staffed vehicle. This includes the more extensive use of an intermediate tier of high dependency vehicles that can be staffed by two intermediate staff or the use of patient transport service vehicles in the same way as is provided for patients who are attending hospital for planned appointments.

3.1.3. PCT funding model

The principles that underly the funding model is that PCTs should contribute to the cost of the ambulance service in proportion to the front line resource that is required to meet an agreed set of performance standards in their own PCT area. These resources are calculated in terms of the rota hours that are required by the ambulance trust to achieve the agreed level of performance based on the volume of EMS activity that occurs within the PCT area, the location of that activity utilising the deployment principles outlined above and the rate of utilisation that can be achieved with those resources. This ensures that each PCT will obtain the same level of Category A 8 minute performance in the respective deployment



areas (urban, semi urban and rural) and will also have sufficient resource to meet the 95% 19 minute standard for Category A and Category B incidents.

While there is some scope for adjusting the model to the needs of a particular PCT area – for example by providing additional resource in certain more rural areas where it is difficult to achieve the Category A 8 minute target – the scope for such adjustments on a PCT by PCT basis is limited by the need for the ambulance trust has to be able to manage its resource on a health economy basis. It is therefore necessary to agree the overall levels of performance and the resource allocation principles that will apply across the whole health economy and only to allow such variations where they can be measured and delivered by the ambulance trust to the PCTs in question without adversely affecting the levels of performance that can be delivered to other PCTs.

3.2. Factors affecting the front line resource requirement and cost of the EMS service

The key factors that affect the resource requirement that is required to deliver a certain level of performance are the level of demand for EMS services, the way that the demand is met by the ambulance trust and the alternative pathways that are available to respond to patients needs.

3.2.1. Demand

The underlying demand for EMS services in each PCT and the amount of resource that has to be planned to respond to that activity varies according to a number of factors. These include

- the absolute level of calls that the Trust receives per head of population,
- the underlying rate of growth of activity,
- the geographic distribution of activity between more densely and less densely populated areas and
- the temporal distribution of the activity both within the day, on different days of the week and at different times of the year
- the distribution of calls between the different call categories

The rate of growth of demand for ambulance has also been significant in recent years. At a national level ambulance activity has grown at an average rate of 3.5% per year and within the West Midlands the rate of growth in recent years has broadly been in line with the national average although this varies significantly between different PCT areas with some areas having rates of growth of 8 - 10% per year while activity is stable or falling in other areas. This rate of growth raises a particular challenge for both ambulance trusts and PCTs as this would suggest that demand management initiatives that have attempted to reduce the public's use of the ambulance service have little effect on the growth in ambulance activity.



Typically, the rate of calls to the ambulance service per head of population is higher in more urban areas and in areas such as the centre of Birmingham where there is a large transient population. The proportion of lower acuity (Category C) calls is also higher in urban areas than in more rural areas. Activity in these areas also tends to be proportionately higher on weekdays and at night time at the weekend. In other more residential areas activity is proportionately higher later in the day and at weekends and there may also be significant seasonal patterns to demand which need to be taken into account by the ambulance trust.

The proportion of calls that are categorised as Category A calls also varies between trusts and in different areas of the same Trust. The rate of categorisation varies from as high as 45% to as low as 26% in different areas. This may reflect a different acuity of calls in different PCT areas, but it also reflects the way that incoming calls are triaged by the trust. One key consideration that influences the percentage of calls that are classified as Category A is the calltaker's knowledge of the call triage system and in particular the extent to which the calltakers have the knowledge and time to ask the supplementary questions which can be used to clarify the nature of the incident. In trusts with the lower rates of Category A calls, effective use of the supplementary questions is often combined with a clinical desk where a caller may be passed from the calltaker to a nurse or Paramedic who continues to talk to the patient whilst at the same time a vehicle is travelling to the incident. In the case of Category C incidents in particular the use of a clinical desk also provides opportunities for rerouting patients to alternatives to an ambulance. This may be NHS Direct or an Out of Hours service or may result in the patient attending a minor injuries unit without the need for an ambulance.

3.2.2. Response model

The amount and type of resource that is required by an ambulance trust to respond to an incident will depend on the response model that the trust employs. Historically ambulance trusts relied extensively on the use of double staffed emergency ambulances to respond to all categories of incident with the result that a relatively large proportion of incidents resulted in the patient being transported to hospital. It is generally recognised however, that this approach to response is inefficient and in many cases does not meet the patient's needs in a timely and appropriate manner whilst at the same time preventing unnecessary admissions to hospital. In this context, it is increasingly recognised that appropriate assessment and triage of the patient's needs at the point at which the patient accesses the healthcare system is key to the delivery of the most appropriate service and the best outcome for the patient.

In recognition of this fact, there has been a significant change in the way in which ambulance trusts respond to 999 emergency calls. At the core of this is the recognition of the need for a separation between the response to the initial emergency and the assessment of the patient's needs from the subsequent process of transporting the patient to hospital once it has been determined that this is the most appropriate response. This has led to an increase in the number of cases where a Rapid Response Vehicle (RRV) staffed by a Paramedic or an Emergency Care Practitioner (ECP) attends an incident prior to a decision to deploy an ambulance with the objective of reducing the number of cases where a double staffed emergency ambulance has to attend an incident. In trusts that have adopted this model of response there has been a significant reduction in the proportion of cases where a double staffed ambulance is required to attend an incident and a corresponding reduction in the



number of patients who are transported to hospital. A further opportunity for efficiency also exists under this model from the use of alternative means of transportation such as high dependency or patient transport vehicles for patients who may need to attend hospital but who do not require urgent transport in a fully equipped emergency ambulance.

3.2.3. Skill mix

The change in the response model to rely more extensively on Paramedics and ECPs to undertake an initial assessment of the patient's needs has resulted in a change in the skill mix and consequently in the average cost of front line staff in ambulance trusts. The implication of the new 'front loaded' model is that RRVs should be staffed by either a Paramedic or an ECP and that all emergency ambulances should also be staffed by a Paramedic together with a technician or an emergency care assistant. A subsequent tier of high dependency vehicles which can be staffed by intermediate staff may then provide transport for urgent and lower acuity emergency incidents. The effect of this is that the skill mix and cost of response will have an effect on the cost of response by both RRVs and ambulances.

3.2.4. Utilisation rates

The rate of ambulance utilisation – i.e. the frequency with which an ambulance attends incidents within a given time period - is a significant factor in determining the amount of resource that an ambulance trust requires and the level of performance that can be achieved with that resource.

In less densely populated areas, there is a limit on the extent to which utilisation can be reduced without compromising performance because of the need to maintain a minimum level of coverage to respond to incidents within the timeframes for the Category A and Category B performance standards. This consideration applies particularly in the more rural PCT areas such as Herefordshire, Shropshire and Warwickshire and will result in a higher cost per incident than applies elsewhere in the WMAS area. In the more densely populated PCT areas, however, where there is a significantly higher rate of 999 calls and consequently a larger number of ambulances available at any time to respond to incidents, there is scope for the utilisation rate to be adjusted and as a result determining the appropriate utilisation for ambulances is a significant factor that needs to be taken into account in determining the quantity of ambulance hours that are required to meet demand in these areas.

It important in this context to note, however, that the utilisation rates that are used in calculating the rotas are averages. In practice utilisation rates will vary significantly from the planned rates both within the day and from day to day as a result of the variability of demand and the effectiveness with which rotas are filled. This means that, even though utilisation may be planned at 50% on average, it will not be unusual for actual utilisation to exceed 80% on particular days. Consequently if the planned utilisation rate is set at too high a rate it creates a risk not only that the performance standards will not be met, but also that that there will be insufficient ambulance resource to meet the level of activity within any reasonable time



In this context there are three considerations that will determine the average level of utilisation that should be assumed within the planned rotas. These are

- the average time that an ambulance is occupied on an incident a shorter cycle time per incident will allow a higher rate of utilisation
- the minimum number of unutilised ambulances that are required to maintain adequate cover for deployment points in addition to RRVs and
- the maximum work rate that it is appropriate to plan from a workforce management perspective.

The appropriate level of planned utilisation in an ambulance trust in more densely populated urban areas is generally below 55% and we have used 52% as the upper limit for the purposes of this exercise. In other areas however where the level of activity is less predictable the level of planned ambulance utilisation can be significantly lower – sometimes as low as 25 - 30% in particularly rural areas

3.2.5. Overtime and extraction rates

The amount of rota hours that is available to an ambulance trust from its front line staff is dependent on two factor - overtime and extractions

Overtime provides a trust with a relatively efficient way of increasing the number of rota hours that are available. This is because overtime payments are not pensionable and overtime hours do not receive an unsocial hours supplement. In addition, unlike the position with normal hours, overtime hours do not have to be adjusted for a relief factor to cover extractions. The use of overtime is therefore an attractive means of creating flexibility in rota planning. At the same time, however, overtime is a relatively unreliable mechanism for filling rota hours as it depends on the willingness of staff to make themselves available to work additional shifts and there is also a limit on the amount of overtime that it is safe for individual members of staff to work. It is important therefore to agree what is an appropriate level of overtime that should be built into the resource plans. In 2008/9 WMAS paid 15% of base salary as overtime payments to its front line staff. Based on the assumption that a core level of overtime of 5% is required to cover normal frictional factors such as overruns at the end of shifts, the remaining 10% of overtime payments were used to cover core rota hours. This implies that 7% of all rota hours in 2008/9 were covered from overtime. We have therefore undertaken our analysis of the resource requirement using two alternative overtime scenarios – the first assumes that the relatively high rate of overtime that was employed in 2008/9 will be maintained; the second assumes that no rota hours are acquired through the use of overtime payments.

The level of relief that the trust builds into its plans is also a critical factor affecting staff numbers and costs. A level of relief has to be built in to resource planning to cover the normal levels of unavailability of staff as a result of factors such as holidays, sickness, training and other planned and unplanned absence. Our analysis of the front line resource requirements are based on two relief scenarios as summarised in Table 2 below.



| Extractions | | Relief |
|-------------------------|-------|--------|
| Total days | 260.7 | |
| Vacation | 29 | |
| Public holidays | 8 | |
| Sickness @ 6% | 15.6 | |
| Maternity leave @ 1.75% | 4.6 | |
| Other @ 0.5% | 1.3 | |
| Minimum extraction rate | 22.4% | 28.8% |
| Training | 9 | |
| Optimum extraction rate | 26% | 35% |

Table 2 Extraction factors and relief rates

This shows that the minimal level of extractions which a trust has to plan for as a result of unavoidable staff absence is 22.4% which requires a relief factor of 28.8%. However this makes no provision for professional training which is particularly important for a trust such as WMAS that not only needs to maintain adequate levels of continuing professional training for its qualified staff but also needs a development programme to upgrade staff from ECA and Technicians to Paramedics. The addition of an appropriate level of training increases the extraction rate from 21.9% to around 26% and results in a relief factor of 35% which is consistent with the level recommended in a Department of Health paper on best practice in managing ambulance trusts which was released in April 2007. Based on these figures we have therefore undertaken our analysis of the front line staff requirement for WMAS using the two scenarios of a minimal relief factor of 28.8% and an optimal relief factor of 35%.

The precise level of relief that will be required remains to be determined based on the detailed requirements of the Trust for training and workforce development – including in particular the requirements for increasing the proportion of paramedics in the workforce - and the most appropriate way in which this can be delivered.

3.2.6. Overheads

The final factor that has to be taken into account in determining the cost of the front line resource that is required to deliver the agreed level of performance is the appropriate level of overheads that are associated with the delivery of the EMS service. These include

 the costs of staff who are involved with management functions including clinical governance etc



- the costs of providing the control function
- IT costs
- fixed overheads such as control rooms, ambulance stations etc
- the cost of vehicles

The ratio of overhead costs (excluding vehicle costs) to front line staff costs is a key factor in the efficiency of an ambulance service. In the case of WMAS this ratio has been calculated by Deloitte as 75% in 2009/10. The result of applying this overhead factor plus the cost of vehicles to front line staff costs produces a fully loaded hourly cost for RRVs of £53 and for double staffed ambulances of £101.



4. Findings

4.1. Activity and achievable performance levels by PCT area

WMAS is a highly urban trust. We have identified 91 urban drive zone locations and 16 semi urban locations and based on these deployment areas, 86% of total activity falls into urban areas, 4% into semi urban areas and 10% into rural areas.

| РСТ | Urban | Semi urban | Rural | Expected Category A performance | Actual Category A performance |
|-----------------------|-------|---------------|-------|---------------------------------------|-------------------------------------|
| B'ham East & North | 100 | 0 | 0 | 85 | 72 |
| Dudley | 100 | 0 | 0 | 85 | 77 |
| Heart of B 'ham | 100 | 0 | 0 | 85 | 76 |
| Sandwell | 100 | 0 | 0 | 85 | 77 |
| Solihull | 82 | 6 | 12 | 79 | 73 |
| South B 'ham | 100 | 0 | 0 | 85 | 71 |
| Walsall | 96 | 4 | 0 | 85 | 71 |
| W'hampton | 100 | 0 | 0 | 85 | 78 |
| BBC | 98 | 1 | 1 | 84 | 74 |
| North Staffs | 85 | 0 | 15 | 78 | 77 |
| Stoke | 97 | 0 | 3 | 84 | 85 |
| South Staffs | 75 | 8 | 17 | 77 | 73 |
| STAFFS | 84 | 4 | 12 | 79 | 78 |
| Coventry | 99 | 0 | 1 | 85 | 82 |
| Warwickshire | 65 | 11 | 24 | 73 | 73 |
| C&W | 80 | 6 | 14 | 78 | 77 |
| Herefordshire | 43 | 24 | 33 | 68 | 73 |
| Shropshire | 39 | 20 | 41 | 65 | 66 |
| Telford | 87 | 8 | 5 | 82 | 83 |
| Worcestershire | 79 | 3 | 18 | 77 | 70 |
| HWS | 66 | 10 | 23 | 73 | 72 |
| | | | | | |
| WMAS | 86 | 4 | 10 | 80 | 75 |

Table 3 Proportion of activity and Category A performance potential by PCT area

Table 3 shows the distribution of activity between urban, semi urban and rural areas in each of the PCT areas in the West Midlands area. This highlights the difference between the majority of PCTs where the activity is highly concentrated in urban areas and the smaller number of PCTs with a significantly higher level of rural activity. Table 3 also shows the level



of Category A performance that could be achieved in each PCT area if the model were applied in full across the whole of the West Midlands area by comparison with the level of performance that was achieved during the reference period for the review. Table 3 also shows that although the achieved level of Category A performance was close to or above the expected level in a number of PCT areas, there were a number of PCT areas where performance was below this level including the majority of the PCTs in Birmingham and the Black Country together with South Staffordshire and Worcestershire.

Table 4 shows the distribution of EMS activity by comparison with the PCT population and the rate of growth in EMS activity in recent years in each PCT area

| РСТ | Population (,000) | Share of population | Incidents per week | Share of total activity | Annual % rate of activity growth |
|-----------------------|----------------------|---------------------|-----------------------|----------------------------|--|
| B'ham East & North | 401.4 | 7.5 | 1130.0 | 7.7 | 5.6 |
| Dudley | 305.4 | 5.7 | 745.0 | 5.1 | 4.9 |
| Heart of B 'ham | 271.7 | 5.0 | 1162.0 | 7.9 | 6.9 |
| Sandwell | 287.5 | 5.3 | 906.0 | 6.2 | 4.9 |
| Solihull | 203.6 | 3.8 | 571.0 | 3.9 | 9.0 |
| South B 'ham | 337.1 | 6.3 | 1061.0 | 7.3 | 6.2 |
| Walsall | 254.5 | 4.7 | 769.0 | 5.3 | 4.6 |
| W'hampton | 236 | 4.4 | 765.0 | 5.2 | 3.7 |
| BBC | 2297.2 | 42.7 | 7109.0 | 48.6 | 5.3 |
| | | | | | |
| North Staffs | 211.8 | 3.9 | 552.0 | 3.8 | 0.8 |
| Stoke | 246.9 | 4.6 | 840.0 | 5.7 | - 0.5 |
| South Staffs | 606.1 | 11.3 | 1377.0 | 9.4 | - 4.0 |
| STAFFS | 1064.8 | 19.8 | 2769.0 | 18.9 | - 2.0 |
| | | | | | 4.0 |
| Coventry | 306.7 | 5.7 | 994.0 | 6.8 | 4.8 |
| Warwickshire | 526.7 | 9.8 | 1319.0 | 9.0 | 5.2 |
| C&W | 833.4 | 15.5 | 2313.0 | 15.8 | 5.0 |
| | | | | | |
| Herefordshire | 178.4 | 3.3 | 209.0 | 1.4 | 10.5* |
| Shropshire | 290.9 | 5.4 | 572.0 | 3.9 | 5.8 |
| Telford | 161.7 | 3.0 | 375.0 | 2.6 | 7.1 |
| Worcestershire | 555.4 | 10.3 | 1276.0 | 8.7 | 5.3* |
| HWS | 1186.4 | 22.0 | 2432.0 | 16.6 | 6.3* |
| | | | | | |
| WMA S | 5381.8 | | 14623.0 | | 4.1 |
| (*) Figures for W | orcestershire an | d Herefordshire | are estimated b | ased on a limited | data period |

Table 4 – Population, EMS activity and growth rates by PCT area

It is clear from Table 4 that there are significant differences in the rate of growth in EMS activity in different parts of the West Midlands



As Table 5 shows, the rate of EMS activity also varies significantly between the different PCT areas with the highest rate of calls in relation to population in Birmingham and the Black Country and the lowest in Hereford, Shropshire and Worcestershire

| РСТ | Total | Category A | Category B | Category C | Urgent |
|------------------------|-------|------------|------------|------------|--------|
| B 'ham East & North | 6.8 | 22.8 | 16.6 | 31.9 | 93.0 |
| Dudley | 7.9 | 25.8 | 19.2 | 40.2 | 90.4 |
| Heart of B 'ham | 4.5 | 14.8 | 10.8 | 20.8 | 72.6 |
| Sandwell | 6.1 | 19.0 | 14.8 | 29.9 | 98.7 |
| Solihull | 6.9 | 24.8 | 16.7 | 35.0 | 59.3 |
| South B 'ham | 6.1 | 20.1 | 15.2 | 29.9 | 67.5 |
| Walsall | 6.4 | 19.4 | 15.5 | 32.8 | 94.1 |
| W'hampton | 5.9 | 19.1 | 14.4 | 32.4 | 63.0 |
| BBC | 6.2 | 20.3 | 15.1 | 30.6 | 78.6 |
| | | | | | |
| North Staffs | 7.4 | 26.4 | 19.6 | 32.8 | 61.7 |
| Stoke | 5.7 | 19.5 | 14.3 | 27.9 | 50.0 |
| South Staffs | 8.5 | 30.4 | 22.2 | 40.2 | 65.5 |
| STAFFS | 7.4 | 26.2 | 19.2 | 35.1 | 60.4 |
| | | | | | |
| Coventry | 5.9 | 27.1 | 13.6 | 26.4 | 49.6 |
| Warwickshire | 7.7 | 35.5 | 17.5 | 35.4 | 60.3 |
| C&W | 6.9 | 31.9 | 15.8 | 31.5 | 55.8 |
| | | | | | |
| Herefordshire | 16.4 | 57.2 | 44.0 | 98.0 | 95.3 |
| Shropshire | 9.8 | 33.7 | 25.9 | 62.2 | 55.9 |
| Telford | 8.3 | 25.5 | 21.4 | 50.2 | 67.6 |
| Worcestershire | 8.4 | 29.5 | 21.2 | 50.1 | 54.5 |
| HWS | 9.4 | 32.1 | 24.2 | 57.0 | 60.4 |
| | | | | | |
| WMA S | 7.1 | 24.8 | 17.4 | 35.3 | 66.1 |

Table 5 – EMS activity by head of population



4.2. Front line staffing requirements

Our analysis of the resource requirement to meet the activity levels outlined in section 4.1 indicates that the current staffing levels and rotas operated by WMAS are inadequate to maintain the required performance standards based on a projected increase in activity in 2009/10 of 4.1% relative to the 2008/9 outturn.

The scale of the shortfall is highlighted in Table 6 which shows the level of activity which WMAS currently undertakes with its existing front line resources. This shows that the planned rate of activity for each ambulance hour in Birmingham and the Black Country is high with 0.81 incidents for each planned hour. The table also shows the number of incidents per year in relation to the number of front line staff in each of the three legacy Trust areas by comparison with the other highly urban ambulance trusts. This shows that WMAS as a whole has the highest rate of activity per front line member of staff. Moreover the rate of activity in Birmingham and the Black Country per member of front line staff is 60% higher than the rate for the London Ambulance Service. At the same time, Table 6 also highlights that WMAS had the lowest ratio of front line staff to total staff of all the comparable trusts.

| | No of incidents per DCA rota hour | No of incidents per member of front line staff | % of staff in frontline positions ⁽¹⁾ |
|---|--|--|--|
| Birmingham and the Black Country | 0.81 | 500 | |
| Staffordshire | 0.67 | 373 | |
| Coventry and Warwickshire | 0.64 | 400 | |
| Herefordshire Shropshire and Worcestershire | 0.45 | 271 | |
| WMAS | 0.64 | 383 | 64.7 |
| London Ambulance Service | | 309 | 70.7 |
| North East Ambulance Service | | 349 | 67.2 |
| North West Ambulance Service | | 365 | 70.8 |
| Yorkshire Ambulance Service | | 299 | 65.5 |
| (1) EMS front line | staff as % of all sta | ff excluding PTS sta | aff |

Table 6 Activity rates per rota hour and per member of front line staff

Our analysis of the number of hours that are required are based on our estimate of the increase in activity in 2009/10 set out in Table 4 above. It also assumes that there is



sufficient resource available to provide RRVs in all the urban locations identified by our deployment analysis and that the ambulance utilisation in urban drive zones is no higher than 52%. Based on these assumptions, Table 7 compares the number of rota hours that would be required in each of the regions of WMAS by comparison with the current planned rotas. This shows that there is a shortfall of RRV rota hours in each of the regions and a shortfall of DCA hours in all regions with the exception of Herefordshire, Worcestershire and Shropshire.

| Current RRV roster | Optimum RRV roster | Current DCA roster | Optimum DCAroster | RRV Shortfall | DCA shortfall | Total shortfall |
|-----------------------|---|--|---|---|--|---|
| 4984 | 7145 | 17180 | 22816 | 2161 | 5636 | 7797 |
| 2378 | 2746 | 8168 | 9874 | 368 | 1706 | 2074 |
| 1256 | 1931 | 6776 | 8268 | 675 | 1492 | 2167 |
| 1256 | 2414 | 11422 | 11012 | 1158 | (410) | 748 |
| 9874 | 14236 | 43456 | 51970 | 4362 | 8424 | 12786 |
| | Current RRV roster 4984 2378 1256 9874 | Current RRV roster Optimum RRV roster 4984 7145 2378 2746 1256 1931 1256 2414 9874 14236 | Current RRV roster Optimum RRV roster Current DCA roster 4984 7145 17180 2378 2746 8168 1256 1931 6776 1256 2414 11422 9874 14236 43456 | Current RRV roster Optimum RRV roster Current DCA roster Optimum DCA 22816 4984 7145 17180 22816 2378 2746 8168 9874 1256 1931 6776 8268 1256 2414 11422 11012 9874 14236 43456 51970 | Current RRV roster Optimum RRV roster Current DCA roster Optimum DCAroster RRV Shortfall 4984 7145 17180 22816 2161 2378 2746 8168 9874 368 1256 1931 6776 8268 675 1256 2414 11422 11012 1158 9874 14236 43456 51970 4362 | Current RRV roster Optimum RRV roster Current DCA roster Optimum DCAroster RRV Shortfall DCA Shortfall 4984 7145 17180 22816 2161 5636 2378 2746 8168 9874 368 1706 1256 1931 6776 8268 675 1492 1256 2414 11422 11012 1158 (410) 9874 14236 43456 51970 4362 8424 |

Table 7 Hours required to fill current and optimum rotas

Available staff to fill the rotas is dependent on the number of front line staff and the rates of overtime and extractions. Table 8 sets out the number of front line staff employed by WMAS as at 30 June 2009 hours and the number of rota hours that could be produced from the current front line staff with the current level of overtime and a minimal level of extractions.

Table 8 Front line staff numbers and available hours to fill rotas

| | ECP/ Paramedics | Technicians | Intermediate staff | Total front line staff | % of ECP/ Paramedics | Maximum hours available | Rota hours | Optimum hours |
|---|--------------------|-------------|-----------------------|---------------------------|-------------------------|-------------------------------|---------------|------------------|
| Birmingham and the Black Country | 307 | 230 | 195 | 732 | 41.9 | 22881 | 22164 | 29961 |
| Staffordshire | 191 | 145 | 55 | 391 | 48.8 | 12200 | 10546 | 12620 |
| Coventry and Warwickshire | 180 | 53 | 29 | 262 | 68.7 | 8186 | 8032 | 10199 |
| Herefordshire Shropshire and Worcestershire | 298 | 110 | 83 | 491 | 60.6 | 15640 | 12678 | 13426 |
| WMAS | 976 | 538 | 362 | 1876 | 52.0 | 58907 | 53420 | 66206 |

This shows that the current front line staff is only just adequate to cover the current rotas in Birmingham and the Black Country at the low level of extraction assumed and would be



insufficient to meet the optimum hours in all regions except Herefordshire, Shropshire and Worcestershire. Table 8 also highlights the low level of Paramedics as a proportion of front line staff in Birmingham and the Black Country. In general, in order for an ambulance trust to be able to staff all its RRVs with a Paramedic and also to be able to ensure that there is a Paramedic on all emergency ambulances the proportion of Paramedics in the total of front line staff would need to be in excess of 65%.¹ Within WMAS, only Coventry and Warwickshire has a Paramedic ratio of over 65% and the ratio of Paramedics to total front line staff in Birmingham and the Black Country is only 41%.

The effect of adjusting the overtime and relief assumptions is shown in Table 9 below. This shows that these adjustments reduce the available hours by a factor of around 10%. On this basis, the current front line staff do not produce sufficient hours to fill the current planned rotas in either Birmingham and the Black Country or in Coventry and Warwickshire and there is a shortfall of 14,147 rota hours for WMAS as a whole by comparison with the optimal rotas.

| | Maximum hours available - Current overtime and relief | Adjustment to 5% overtime | Adjustment to 35% relief | Adjusted maximum hours | Difference from current rotas | Difference from optimum rotas |
|---|--|---------------------------------|-----------------------------|------------------------------|-------------------------------------|-------------------------------------|
| Birmingham and the Black Country | 22343 | (1443) | (1125) | 20313 | <mark>(1851)</mark> | (9648) |
| Staffordshire | 11904 | (749) | (403) | 10850 | 304 | (1770) |
| Coventry and Warwickshire | 8699 | (513) | (601) | 7270 | (762) | (2929) |
| Herefordshire Shropshire and Worcestershire | 14986 | (1260) | (755) | 13625 | 947 | 199 |
| WMAS | 57935 | (3964) | (2884) | 52059 | (1361) | (14147) |

Table 9 - Impact of adjustments to overtime and relief factors on available hours

Based on these assumptions, the additional front line resource and the associated staff costs that would be required to fill the optimum rotas under the three scenarios of unchanged overtime and relief, a minimal reliance on overtime and a relief factor of 35% are set out in Table 10. This shows that a minimum of 231 additional staff would be required by WMAS at an additional salary cost of £10,272,000 if the Trust was to be able to resource the optimum rotas based on current overtime rates and a minimal level of extractions. This requirement for additional staff would increase to 473 at an additional cost of £16,161,000 if the Trust ceased to rely on overtime to fill shifts and increased its extraction rate to 28% – the rate that was recommended for ambulance trusts in 2007 in order to provide sufficient

¹ The percentage of paramedics that an ambulance trust requires will depend on the fleet mix that is deployed. The figure of 65% is based on the assumption that a high dependency tier which does not require a paramedic is used to transport urgent and lower acuity AS1 patients



time for ongoing training. It is also important to note that the increase in staff would still leave WMAS with a ratio of Paramedics to total front line staff that is below 60%. This reflects the fact that the rate at which it is possible to upskill staff is limited and depends on the rate at which existing staff can progress through the relevant training programmes. In order to achieve a 65% paramedic ratio under this scenario, WMAS would need to increase its total number of paramedics to 1409 – an increase of 44% from the current level.

| | Current front line staff | Front line staff Optimal rotas Current overtime 22.4% extractions | Front line staff Optimal rotas 5% overtime 22.4% extractions | Front line staff Optimal rotas 5% overtime 28% extractions | Shortfall relative to optimal rotas 5% overtime 28% extractions |
|---------------------------------|-----------------------------|--|---|---|--|
| Paramedics | 976 | 1152 | 1251 | 1312 | 336 |
| Technicians | 538 | 593 | 644 | 675 | 137 |
| Emergency Care Assistants | 362 | 362 | 362 | 362 | - |
| TOTAL | 1876 | 2107 | 2257 | 2349 | 473 |
| | | | | | |
| Cost (£,000) | 75,996 | 86,267 | 88,321 | 92,157 | |
| | | | | | |
| Paramedic % | 52 | 55 | 55 | 56 | |

Table 10 Front line staff required to fill optimal rotas

4.3. Potential adjustments to front line resource requirements

It is important to note that the optimal rotas included in Section 4.2 above are based on a number of key assumptions which have a material impact on the amount of resource that will be required by WMAS. In particular, it assumes that

- WMAS will continue to send the same number of ambulances to attend incidents as occurs at present despite the fact that the response model assumes that there will be an increase in the number of RRVs that will be providing the initial response to incidents
- The average ambulance utilisation rates will be no higher than 52% in the main urban areas.
- The target level for Category A performance in urban areas should be the same level in all areas of the West Midlands

Adjustments to these assumptions have a material effect on the amount of resource that will be required by WMAS as well as the levels of performance that the Trust will be able to achieve at both the 8 minute and the 19 minute levels.



4.3.1. Attendance and transportation rates

As Table 11 shows, there are appreciable differences in practice across the different regions of WMAS with respect to both ambulance and RRV attendance rates and hospital transportation ratios for the different categories of 999 calls.

| | Category A Ambulance | Category A RRV | Category A Transport | Category B Ambulance | Category B RRV | Category B Transport | Category C Ambulance | Category C RRV | Category C Transport |
|--|-------------------------|-------------------|-------------------------|-------------------------|-------------------|-------------------------|-------------------------|-------------------|-------------------------|
| Birmingham and the Black Country | 99.6 | 56.1 | 76.1 | 84.7 | 40.4 | 61,2 | 51.6 | 24.2 | 33.4 |
| Staffordshire | 88.1 | 44.9 | 64.4 | 80.1 | 42.1 | 56.4 | 76.3 | 43.1 | 52.8 |
| Coventry and Warwickshire | 93.9 | 29.0 | 69.3 | 82.8 | 27.0 | 55.3 | 72.8 | 27.0 | 47.1 |
| Herefordshire Shropshire and Worcestershire | 1.09 | 26.6 | 73.6 | 94.6 | 26.9 | 58.7 | 69.0 | 20.3 | 35.8 |
| WMAS | 98.6 | 45.6 | 72.9 | 85.3 | 36.1 | 59.1 | 62.5 | 27.6 | 39.7 |
| Potential reduction per week | 425 | | 347 | 303 | | 193 | 312 | | 181 |

Table 11 Attendance and transportation ratios

This confirms that very different response models currently operate in the different regions of WMAS with differences in the way in which RRVs and ambulances are used and with different outcomes in terms of the rate at which patients are transported to hospital with Staffordshire having the lowest rate of transportation for both Category A and Category B calls, but the highest rate for Category C calls. There are also materially different rates at which RRVs are employed in the different areas with the highest rate being employed in Birmingham and the Black Country and the lowest rate being employed in Herefordshire, Worcestershire and Shropshire.

Based on these figures there does appear to be scope to reduce the rate of ambulance attendance at all categories of incident and as a result to reduce the number of ambulance hours that would be required relative to the number included in Table 7. Indeed if the ambulance attendance rate were to reduce across WMAS to the lowest rates in each of the incident categories this would reduce the total rota hours requirement by around 4000 per week.

As Table 11 shows a further opportunity also exists to reduce the number of cases that are transported to hospital by up to 721 cases per week.

4.3.2. Ambulance utilisation rates

Our analysis of the optimum rotas that are set out in Table 7 are based on the assumption that the planned level of ambulance utilisation will not exceed a maximum rate of 52%. In the



WMAS area, however, there may be scope to increase the planned utilisation rate above 52% in the more densely populated areas, and in particular within Birmingham and the Black Country. Table 12 shows the potential reduction in ambulance unit hours that could be achievable if ambulance utilisation rates were increased to 55% in those urban areas where we believe that this might be possible without compromising overall performance.

| | Ambulance utilisation Jan – March 2009 | Forecast attendances per week 2009/10 | Proposed utilisation | Number of ambulance unit hours required | Potential increased utilisation | Number of ambulance unit hours required | Rota hours saved |
|---|---|--|-------------------------|--|---------------------------------------|--|---------------------|
| Birmingham and the Black Country | 73% | 5932 | 52% | 11408 | 55% | 10785 | 1246 |
| Staffordshire | 56% | 2359 | 48% | 4937 | 53% | 4454 | 966 |
| Coventry and Warwickshire | 59% | 1978 | 48% | 4134 | 49% | 4037 | 194 |
| Herefordshire Shropshire and Worcestershire | 41% | 2469 | 45% | 5506 | 46% | 5344 | 324 |
| WMAS | 61% | 12738 | 49% | 25985 | 52% | 24620 | 2730 |

Table 12 Ambulance utilisation rates

This shows that changing the planned rate of utilisation has a significant effect on the overall resource requirement for WMAS. The increase in the planned utilisation rate from 49% to 52% saves a total of 2730 rota hours per week. It will therefore be important for WMAS and the PCTs to agree the appropriate maximum utilisation rate that should apply in determining the amount of front line resource that is required to respond to the level of activity in each PCT area.

4.3.3. Target Category A urban performance

The recommended rota hours are also based on the assumption that WMAS will resource an RRV rota that will provide sufficient resource to deploy RRVs in all the urban deployment areas that we have identified across the West Midlands health economy in order to deliver the consistent level of Category A performance on a PCT by PCT basis as set out in Table 3. As outlined in Section 3 above, the objective of this approach is to ensure that there is equity of service to patients who live in similar areas across the West Midlands and to avoid areas of low performance within larger areas where performance may on average be higher. A consequence of this approach however is that there will be certain areas where the cost of achieving this level of performance will be relatively high because of a smaller number of Category A incidents within a deployment area. Moreover, applying this approach will mean that Category A performance for WMAS as a whole and in certain PCT areas will be significantly above the 8 minute standard of 75%.



This position applies most particularly to the PCT areas within Birmingham and the Black Country, where the level of RRV resource recommended would deliver an overall level of performance of 84% and contributes significantly to the outperformance of WMAS against the national standard of 75% that is implied in Table 3.

It would therefore be possible for WMAS to plan for a lower level of Category A performance in Birmingham and the Black Country by reducing the amount of RRV resource that is available to respond to Category A incidents. As Table 13 shows, we have identified 44 deployment areas within Birmingham and the Black Country each of which has an average of 42 Category A incidents per week. However, the nine lowest activity deployment areas in Birmingham and the Black Country have around half the average level of Category A activity per week of the median deployment area and account for only 10% of the overall Category A activity. By reducing the amount of RRV resource available, we estimate that Category A performance in these deployment areas would fall from 85% to around 65% at a saving of 1134 hours per week. This would reduce overall Category A performance in Birmingham and the Black Country by 3 percentage points from 84% to 81% but would still leave the overall Category A performance of WMAS at around 78%

| Total number of deployment areas | Weekly Category A activity in median deployment area | Total RRV hours | No of deployment areas accounting for lowest 10% of activity | Average Category A activity per deployment area | Total RRV hours saved | Potential loss of CatA performance | Potential Category A performance in lower activity deployment areas |
|---|---|--------------------|--|---|--------------------------|---|---|
| 44 | 42 | 7145 | 9 | 23 | 1134 | 3% | 65% |

Table 13 Potential reduction in RRV rota hours in Birmingham and the Black Country

4.3.4. Potential savings in rota hours and additional resource requirement

Table 14 summarises the potential savings in rota hours that might be available from the three scenarios outlined above.

This highlights that there are significant opportunities for savings in the front line resource that WMAS would require to deliver performance relative to the base case requirements outlined in Section 4.2 above. However, it will require careful planning and management by WMAS to ensure that the savings that are potentially available under the different scenarios are effectively managed and do not have any unanticipated adverse consequences on performance or clinical outcomes. Moreover, the opportunities for efficiencies from lower attendance and transportation ratios - which provide the greatest opportunity for savings in rota hours - will also require input from other parts of the health economy to ensure that alternative pathways are available for patients other than attending A&E departments.



| Scenario | Rota hours saved Ambulance | Rota hours saved RRV | Saving current overtime 22.4% extractions (£,000) | Saving 5% overtime 22.4% extractions (£,000) | Saving 5% overtime 28% extractions (£,000) |
|---|----------------------------------|----------------------------|---|--|--|
| Reduced Category A performance in Birmingham and Black Country | | 1134 | 1,682 | 1,731 | 1,816 |
| Increase ambulance urban utilisation from 52% to 55% | 2730 | | 3,661 | 3,779 | 3,963 |
| Reduce ambulance attendance rates to lowest benchmark | 4000 | | 5,366 | 5,537 | 5,806 |
| TOTAL | <u>6730</u> | <u>1134</u> | <u>10,709</u> | <u>11,047</u> | <u>11,585</u> |

Table 14 Potential savings in rota hours and front line staff costs

4.4. Factors affecting the funding requirement to meet the shortfall in front line staff

Our analysis suggests that WMAS will require additional funding in order to provide the level of front line staff that will be required in order to maintain the required level of performance across the West Midlands health economy in 2009/10. However, a number of considerations need to be taken into account in determining the precise amount of the additional funding that is required by WMAS.

In particular, it should be noted that our analysis was based on the numbers of front line staff in post in June 2009. It does not take into account any additional staff that WMAS plan to recruit which will be paid for out of the additional funding that has already been agreed for 2009/10. Moreover it does not factor in the additional funding that WMAS will also receive if activity continues at the current rates of growth.

In addition, as Table 15 shows, the analysis by Deloittes of the planned increases in pay costs at WMAS in 2009/10 highlights the fact that the proportion of EMS staff costs accounted for by front line staff is planned to fall from 55.2% of total EMS costs in 2008/9 to 52.9% in 2009/10 while the proportion of costs accounted for by non front line staff is planned to increase from 13.1% of EMS costs to 15.7%. A significant part of this increase is accounted for by initiatives such as increased training and emergency preparedness which were previously agreed with the PCTs.



| | 2009/10 (£ ,000) | % of total EMS costs | 2008/9 (£ ,000) | % of total EMS costs |
|----------------------|---------------------|-------------------------|--------------------|-------------------------|
| Operational rota | 73,789 | 51.8 | 71,637 | 54.7 |
| Reserves | 1,600 | 1.1 | 677 | 0.5 |
| Operational rota pay | 75,389 | 52.9 | 72,315 | 55.2 |
| | | | | |
| Control pay | 12,321 | 8.6 | 10,615 | 8.1 |
| | | | | |
| Central Services | 7,320 | 5.1 | 5,800 | 4.4 |
| Training | 1,520 | 1.1 | 1,222 | 0.9 |
| A&E management | 7,119 | 5.0 | 5,745 | 4.4 |
| Central Admin | 2,034 | 1.4 | 2,063 | 1.6 |
| E&U Admin | 1,030 | 0.7 | 1,030 | 0.8 |
| Fleet maintenance | 1,000 | 0.7 | 930 | 0.7 |
| Other | 2,358 | 1.7 | 412 | 0.3 |
| Non Operational pay | 22,381 | 15.7 | 17,201 | 13.1 |
| | | | | |
| Total EMS pay costs | 110,091 | 77.2 | 100,130 | 76.4 |

Table 15 Planned changes in EMS pay costs between 2008/9 and 2009/10

This further underlines the need to ensure that there is a full understanding of the cost base at WMAS and in particular the elements that contribute to the non front line costs so that agreement can be reached about the level of additional funding that is required to provide the appropriate level of front line staffing.

4.5. PCT shares of funding

As outlined in Section 4.1 the current funding arrangements for WMAS do not reflect the current pattern of EMS activity or the level of front line resource that are required to maintain agreed levels of performance across the different PCT areas.

Table 16 compares the current funding arrangements for WMAS with the current levels of activity and the current distribution of front line resource for each PCT and compares this with the optimal level of resource that we have estimated would be required in each PCT area to maintain a consistent level of performance across all PCT areas as outlined in Table 3 above.² This shows that the current level of funding is broadly in line with the front line resources that are currently deployed by WMAS in the different PCT areas but it also shows that there is a significant disparity between the current funding arrangements and the resource that would be required in each PCT area under the optimal model.

² A more detailed analysis of EMS activity and the related proposed resource requirement by PCT is shown in Appendix 1



It should be noted however that this analysis makes no allowance for the possible reductions in resourcing that WMAS may be able to achieve relative to the optimal rotas as outlined in Section 4.3 which would help to reduce the required rota hours relative to the optimal level particularly in the more urban areas of the Trust.

| РСТ | % activity | % current hours | % optimal hours funding | % LDP funding |
|--------------------|------------|-----------------|----------------------------|---------------|
| B'ham East & North | 7.8 | 7.1 | 7.3 | 6.8 |
| Dudley | 5.3 | 4.4 | 4.8 | 5.5 |
| Heart of B 'ham | 7.0 | 6.2 | 7.0 | 5.2 |
| Sandwell | 6.4 | 5.3 | 5.8 | 5.0 |
| Solihull | 4.1 | 3.5 | 3.8 | 3.7 |
| South B 'ham | 7.3 | 6.2 | 6.8 | 6.2 |
| Walsall | 5.3 | 4.4 | 5.0 | 4.5 |
| W'hampton | 5.3 | 4.4 | 4.8 | 4.3 |
| BBC | 48.5 | 41.5 | 45.3 | 41.2 |
| | | | | |
| North Staffs | 4.1 | 3.8 | 3.7 | 4.0 |
| Stoke | 5.8 | 5.6 | 5.8 | 5.6 |
| South Staffs | 10.6 | 10.3 | 9.6 | 10.3 |
| STAFFS | 20.5 | 19.7 | 19.1 | 19.9 |
| | | | | |
| Coventry | 5.9 | 6.1 | 6.2 | 5.5 |
| Warwickshire | 8.0 | 9.0 | 9.2 | 9.6 |
| C&W | 13.9 | 15.0 | 15.4 | 15.1 |
| | | | | |
| Herefordshire | 2.4 | 3.2 | 2.8 | 4.3 |
| Shropshire | 3.7 | 6.3 | 5.3 | 5.7 |
| Telford | 2.6 | 4.0 | 3.5 | 3.3 |
| Worcestershire | 8.4 | 10.2 | 8.7 | 10.5 |
| HWS | 17.1 | 23.7 | 20.2 | 23.8 |
| | | | | |

Table 16 – PCT shares of activity, rota hours and LDP funding

This underlines the need to establish an agreed model of response and funding in order to maintain an agreed common level of performance in the more urban areas of the West Midlands health economy and a different model of response and funding that can apply in the more rural areas.

4.6. Clinical issues

In the course of our review we identified a number of issues of concern in relation to the clinical aspects of the Trust's activities and in particular the implications of the current



pressures that the Trust faces in Birmingham and the Black Country for the quality of clinical care that can be provided. This is compounded by the fact that the skill mix of staff in Birmingham and the Black Country has a low proportion of Paramedics and as a result relies heavily on the use of Technicians and Emergency Care Assistants to fill the rotas. As a result RRVs are often staffed by Technicians and emergency ambulances will be staffed on a regular basis by a combination of Technicians and ECAs. There is also a relatively low rate of usage across WMAS of Advanced Paramedics and Emergency Care Practitioners.

From an organisational perspective, the Clinical Directorate operates as two teams, one led by the Medical Director and the other led by the Nurse Director which is a new appointment and also supports the Foundation Trust (FT) application. The Medical Director has two full time clinical managers, one for Heart and Stroke and one for clinical evidence, who has a small audit team. The Nurse Director has a Regional Infection Control Manager, a Clinical manager for Obstetrics and Paediatrics, two part time medicines management personnel and an external pharmacist. The Commissioners have established a Clinical Quality Group which is the only formal clinical link between the Trusts and the PCTs, but this meets on an infrequent basis, and there is no clinical forum with secondary care partners, apart from the quarterly meeting of the Medical Directors.

The approach to clinical oversight seems to be largely reactive although a clinical strategy document is currently being formalised in the context of the Trust's business planning exercise. WMAS uses national clinical outcome measures to measure its clinical performance. There is currently no proactive analysis of trends and the audit team is primarily occupied in preparing PCT level information about performance against the national targets. Ongoing clinical education for staff appears to be very dependent on cascading information to stations and there is no process for ensuring that staff have read or understood the information that is provided to them. Moreover the level of clinical input to incidents and clinical supervision and support for front line staff is very variable between the divisions.

There is an established structure for clinical supervision of front line staff in Coventry and Warwickshire and there is a telemedicine desk in Staffordshire that provides clinical advice to both front line and control room staff in Staffordshire but it is unclear how clinical support is made available to front line staff in the other two regions. The availability of alternative care pathways is inconsistent across the West Midlands. The absence of information about alternative pathways that may be available for patients together with the pressures on crews to meet the performance standards is leading to more patients being transported to hospital than might otherwise be necessary.

There is also a range of practice in dealing with Category C calls. There is some clinical triage of calls by a paramedic clinical support desk in BBC but none by nurses or other professionals. However, when clients are passed between NHS Direct and WMAS, the first triage assessment is not usually accepted leading to duplication, and patient dissatisfaction and frustration.

Relations with hospitals are generally better than in many other ambulance trust areas. The time spent by crews at hospital is short by comparison with other trusts and the impact of the



HALOs (Hospital Ambulance Liaison officers) who have been introduced to proactively manage turnaround times together with the touch screens in the A&E departments have been seen as a very positive initiative by the Trust. However there are concerns about the way that the urgent work is often held back because of pressure of work and then dealt with on a batched basis later in the day which leads to scheduling problems at the Acute Trusts. The daily reports that WMAS produces for the Acute Trusts are appreciated but could be usefully complemented by weekly and monthly reports that highlight emerging trends in the data.

A key issue for WMAS is the need to upskill its workforce from the current low level of qualified paramedics. The Trust's objective is to reach a 70% Paramedic workforce within 5 years and the courses to upgrade staff from ECA to Technician are currently running at full capacity. However, continuing recruitment of ECAs to fill the resource gap will require ongoing provision of a high level of training to achieve the level of upskilling of the workforce that will be required during this period.

4.7. Organisational and managerial issues

It was clear from our review that WMAS has made relatively little progress towards developing a single Trust wide way of managing the EMS service and until recently has operated through the structures and processes of the four legacy divisions although the recent restructuring of the operations management into two divisions – North and South – is intended to address this issue. The focus of the Trust management and the commissioning PCTs since the Trust was created in 2007 has been on the achievement of performance standards and as a result there appears to have been relatively little focus on the development of a longer term strategic development plan for the Trust.

We also believe that the management structure at WMAS is very lean. The role of Director of Operations has been combined with IT in a new role of Director of Service Delivery. The Director of Service Delivery is supported by two Regional Directors for the newly formed North and South regions .Patient Transport Services are run separately from the EMS service and does not have a reporting line to the Director of Service Delivery.

During our review it was clear that the Trust was under extreme resource pressure particularly in Birmingham and the Black Country. Particular symptoms of this that we observed were managers continually responding to incidents rather managing performance and a high level of sickness and turnover among the senior managers. It was also clear that the Trust lacks reliable and timely management information about the factors affecting performance. In particular we noted a lack of information other than in Staffordshire about rota coverage and resource utilisation which created a problem for senior management in highlighting emerging trends in the ability of the Trust to maintain adequate levels of coverage and performance. There was also a lack of information about particular areas of underperformance and clinical risk. This is an area that has been recognised by WMAS as a



priority and initiatives are now under way to provide operational management with improved and timely management information.

There are areas of good practice in different parts of the Trust such as the dynamic rostering process that has been used in Staffordshire for a number of years – but there is no formal mechanism to ensure that this is shared across the Trust. It is also unclear how performance management and service improvement is managed and embedded within the organisation. The Trust has a small service improvement team, but their time is primarily spent on trouble shooting assignments rather than developing improved processes.

The Trust is currently in the process of introducing a new CAD system that will operate across all three control rooms. The new CAD is currently operational in Brierley Hill and covers Birmingham and the Black Country as well as Worcestershire and Herefordshire. The closure of Bransford and the transfer of Worcestershire and Herefordshire's Emergency Operations Centre to Brierley Hill gave rise to some concerns as a result of the increase in the proportion of incidents that were categorised as Category A calls as well as an overall increase in the level of activity that was reported for the two PCTs following the move. There are examples of good practice within the different control rooms including the clinical desk in Birmingham and the Black Country and the telemedicine desk in Staffordshire and there is scope for these practices to be rolled out to the other control rooms. There is also a good structure for AMPDS training, and a dedicated EOC training team working with established dispatch protocols although the availability and use of RRVs and ambulances differs between the different control rooms.

The focus on the delivery of performance has also meant that there has been little time for training and personal development at all levels within the Trust. This has resulted in a backlog of training requirements which has had to be addressed in order to ensure that the minimum levels of mandatory training are maintained and that the training that is necessary to progress staff from ECAs and Technicians to Paramedics can be undertaken. The need to undertake this training has however increased the shortfall of staff available to fill the rotas and has added further to the resource pressure that the Trust is facing.



5. Conclusions and recommendations

5.1. Conclusions

It is clear from our review that there are grounds for concern about the sustainability of performance and the clinical effectiveness of WMAS in its current situation and a need for a rebasing of the resource that WMAS has available particularly in Birmingham and the Black Country. At the same time there are a number of management and organisational changes that WMAS needs to make if it is to provide the level of service that will be expected of an ambulance trust over the next five to ten years.

The key findings from our review of the effectiveness and efficiency of WMAS are as follows

- Based on current ways of working, WMAS will require a considerable number of additional staff to meet national targets, particularly in the more urban areas of the Region. We would propose a review of innovative approaches to delivering front line provision of urgent care, alongside a review of the workforce requirements.
- In the medium to longer term, we would propose a review of innovative approaches to delivering front line provision of urgent care, alongside a review of the workforce requirements and training.
- The current arrangements for clinical oversight and governance at WMAS could be improved by involving representatives from the rest of the urgent care network in the West Midlands.
- WMAS and PCTs should work in partnership to agree on an appropriate level of funding to ensure national response standards are met.
- The current response model in WMAS relies on Technicians and Emergency Care Assistants (ECAs). To improve access to alternative care pathways it is recommended that a review of paramedic workforce requirements is undertaken.
- The current funding arrangements largely reflect the population base of the PCTs and do not reflect the current level and growth of EMS activity across the West Midlands health economy. A new model of response and funding is required that distinguishes between the requirements of the highly urban areas and the more rural parts of the health economy.
- Since the creation of WMAS there has been a focus by WMAS and Commissioners on achieving short term performance at the expense of developing strategic direction
- WMAS operates on the basis of the four legacy organisations and in some areas has still to develop a common operational approach across the Trust



- The management structure at WMAS is lean and depends heavily on a limited number of key executives and middle managers
- WMAS and the PCT Commissioners need to establish a more sophisticated mechanism for analysing the patterns of demand for EMS services and for identifying the factors underlying changes in activity
- WMAS needs to ensure that the management information collected is used to identify emerging trends in its performance and lacks a trust wide performance management structure to manage and monitor the introduction of new operational processes
- There is scope for reducing the rate of ambulance attendance and transportation particularly in relation to Category B and Category C incidents through the use of new and innovative ways of responding
- There are areas of good practice within the four legacy Localities of WMAS but mechanisms need to be established to ensure these are shared and implemented across the whole Trust where appropriate

5.2. Recommendations

Based on our findings and conclusions set out above we would make the following recommendations with respect to the actions that we believe are required to address the immediate performance issues that WMAS faces and to enable the key stakeholders in the West Midlands to plan for the future delivery of an effective and efficient urgent care service

- WMAS and the Commissioners should agree a strategic vision for the delivery of unscheduled care across the West Midlands health economy over the next five years together with an agreed funding model for WMAS.
- A performance group should be established to agree the role that WMAS should play in the delivery of the strategic plan for unscheduled care and to monitor the delivery of the plan.
- The performance group should agree the response models and the associated levels of performance that should apply in the urban areas and the rural areas of the West Midlands health economy and to agree the other planning assumptions that are required in order to establish the level of front line resource and the associated funding that WMAS will require to meet the agreed performance standards
- A review should be conducted of the cost structure at WMAS with a particular focus on the level of overhead costs that are required to support the agreed level of front line staff
- A clinical oversight group should be established with participation from all key stakeholders to ensure that there is appropriate engagement between WMAS and the rest of the urgent care system with respect to clinical outcomes



- WMAS should seek to strengthen its senior management team with a particular focus on its strategic planning and programme management capabilities
- WMAS should establish a medium term workforce development plan with the objective of achieving a minimum level of 60% of Paramedics within 3 years
- WMAS should establish a common approach to performance management across all four of the legacy operating areas based on a common management information system that can identify emerging trends and ensure that the impact of new initiatives is measured and understood
- WMAS should establish a common approach to rota management and resource utilisation in order to ensure that the available front line resources are being used effectively
- WMAS should establish a common deployment planning methodology that uses the principles of deployment areas and system status planning in order to ensure that performance is delivered in a consistent manner across all the PCT areas.
- WMAS should establish a common approach to the use of a clinical desk in each of the control rooms to provide telephone triage for Category B and Category C incidents and to provide clinical support for front line staff
- WMAS should establish a fully costed plan for the changes that will be required to deliver the necessary improvements to its service and should establish a programme management and governance framework in coordination with the PCTs to ensure the successful delivery of the programme



Appendix 1 – PCT activity and resource requirements

BIRMINGHAM AND THE BLACK COUNTRY

| <u>Birmingham</u> East and North | Category A | Category B | Category C | Urgent / Routine | Total | <u>Dudley</u> | Category A | Category B | Category C | Urgent / Routine | Total |
|---|-----------------------------------|-----------------------------------|--|---------------------------|---|--|-----------------------------------|-----------------------------------|----------------------------------|---------------------------|---|
| | | | | | | | | | | | |
| Urban | 339 | 466 | 242 | 83 | 1130 | Urban | 228 | 306 | 146 | 65 | 745 |
| Semi Urban | | | | | | Semi Urban | | | | | |
| Rural | | | | | | Rural | | | | | |
| RRV utilisation | | | | | 0.33 | RRV utilisation | | | | | 0.33 |
| RRV hours | | | | | 1213 | RRV hours | | | | | 805 |
| DCA AS1 | 1 | 0.82 | 0.49 | | 0.8 | DCA AS1 attendance | 0.97 | 0.82 | 0.52 | | 0.8 |
| DCA AS1 | 0.74 | 0.59 | 0.31 | | 0.57 | DCA AS1 transportation | 0.78 | 0.6 | 0.33 | | 0.60 |
| DCAutilisation | | | | | 0.5 | DCAutilisation | | | | | 0.52 |
| DCAhours | | | | | 1804 | DCAhours | | | | | 1194 |
| Cat A | | | | | 85% | Cat A Performance | | | | | 85% |
| % of contract | | | | | 7.30% | % of contract | | | | | 4.80% |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Heart of | Category A | Category B | Category C | Urgent / | Total | Orachuall | 0.1 | Ortoner | 0.1 | Urgent / | Tabal |
| Heart of Birmingham | Category A | Category B | Category C | Urgent / Routine | Total | Sandwell | Category A | Category B | Category C | Urgent / Routine | Total |
| Heart of Birmingham | Category A | Category B | Category C | Urgent / Routine | Total | Sandwell | Category A | Category B | Category C | Urgent / Routine | Total |
| Heart of Birmingham Urban | Category A 353 | Category B 486 | Category C 251 | Urgent / Routine 72 | Total 1162 | <u>Sandwell</u> Urban | Category A | Category B 374 | Category C | Urgent / Routine | Total 906 |
| Heart of Birmingham Urban Semi Urban | Category A 353 | Category B 486 | Category C 251 | Urgent / Routine 72 | Total 1162 | Sandwell Urban Semi Urban | Category A 291 | Category B 374 | Category C 185 | Urgent / Routine 56 | Total 906 |
| Heart.of Birmingham Urban Semi Urban Rural | Category A 353 | Category B 486 | Category C 251 | Urgent / Routine 72 | Total 1162 | Sandwell Urban Semi Urban Rural | Category A 291 | Category B 374 | Category C | Urgent / Routine 56 | Total 906 |
| Heart of Birmingham Urban Semi Urban Rural RRV utilisation | Category A 353 | Category B | Category C 251 | Urgent / Routine 72 | Total 1162 0.42 | Sandwell Urban Semi Urban Rural RRV utilisation | Category A 291 | Category B 374 | Category C 185 | Urgent / Routine 56 | Total 906 0.34 |
| Heart of Birmingham Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 | Category A 353 | Category B 486 | Category C 251 | Urgent / Routine 72 | Total 1162 0.42 998 | Sandwell Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 | 291 | Category B 374 | Category C 185 | Urgent / Routine | Total 906 0.34 971 |
| Heart of Birmingham Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 | Category A 353 | Category B 486 0.87 | Category C 251 0 | Urgent / Routine 72 | Total 1162 0.42 998 0.83 | Sandwell Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance | Category A 291 | Category B 374 0.85 | Category C 185 0.5 | Urgent / Routine 56 | Total 906 0.34 971 0.82 |
| Heart of Birmingham Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 transportation | Category A 353 1.01 0.74 | Category B 486 0.87 0.62 | Category C 251 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | Urgent / Routine 72 | Total 1162 0.42 998 0.83 0.59 | Sandwell Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 transportation | Category A 291 0.99 0.76 | Category B 374 0.85 0.65 | Category C 185 0.5 0.35 | Urgent / Routine 56 | Total 906 0.34 971 0.82 0.62 |
| Heart of Birmingham Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation | Category A 353 1.01 0.74 | Category B 486 0.87 0.62 | Category C 251 0.48 0.32 | Urgent / Routine 72 | Total 1162 0.42 998 0.83 0.59 0.52 | Sandwell Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation | Category A 291 0.99 0.76 | Category B 374 0.85 0.65 | Category C 185 0.5 0.35 | Urgent / Routine 56 | Total 906 0.34 971 0.82 0.62 0.52 |
| Heart of Birmingham Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA hours Cat A | Category A 353 1.01 0.74 | Category B 486 0.87 0.62 | Category C 251 0.48 0.32 | Urgent / Routine 72 | Total 1162 0.42 998 0.83 0.59 0.52 1826 | Sandwell Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 attendance DCA AS1 otransportation DCA utilisation DCA hours | Category A 291 0.99 0.76 | Category B 374 0.85 0.65 | Category C 185 0.5 0.35 | Urgent / Routine 56 | Total 906 0.34 971 0.82 0.62 0.52 1421 |
| Heart of Birmingham Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 transportation DCA utilisation DCA utilisation DCA hours Cat A Performance | Category A 353 1.01 0.74 | Category B 486 0.87 0.62 | Category C 251 0.48 0.32 | Urgent / Routine 72 | Total 1162 0.42 998 0.83 0.59 0.52 1826 85% | Sandwell Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA utilisation DCA hours Cat A Performance | Category A 291 0.99 0.76 | Category B 374 0.85 0.65 | Category C 185 0.5 0.35 | Urgent / Routine 56 | Total 906 0.34 971 0.82 0.52 1421 85% |
| Heart of Birmingham Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA hours Cat A Performance % of contract | Category A 353 1.01 0.74 | Category B 486 0.87 0.62 | Category C 251 0.48 0.32 | Vrgent / Routine 72 | Total 1162 0.42 998 0.83 0.59 0.52 1826 85% 7% | Sandwell Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA utilisation DCA hours Cat A Performance % of contract | Category A 291 | Category B 374 0.85 0.65 | Category C 185 0.5 0.35 | Urgent / Routine 56 | Total 906 0.34 971 0.82 0.62 1.62 1.52 1.52 5.80% |



| <u>Solihull</u> | Category A | Category B | Category C | Urgent / Routine | Total | <u>South</u> Birmingham | Category A | Category B | Category C | Urgent / Routine | Т |
|--|---|---|---|--------------------------------|--|---|--|--|---|--------------------------------|--|
| | | | | | | | | | | | |
| Urban | 130 | 193 | 92 | 54 | 469 | Urban | 322 | 426 | 217 | 96 | 10 |
| Semi Urban | 9 | 14 | 7 | 4 | 34 | Semi Urban | | | | | |
| Rural | 19 | 28 | 13 | 8 | 68 | Rural | | | | | |
| RRV utilisation | | | | | 0.28 | RRV utilisation | | | | | 0. |
| RRV hours | | | | | 612 | RRV hours | | | | | 97 |
| DCA AS1 attendance | 0.96 | 0.82 | 0.55 | | 0.8 | DCA AS1 attendance | 1.06 | 0.88 | 0.55 | | 0. |
| DCA AS1 transportation | 0.77 | 0.54 | 0.33 | | 0.57 | DCA AS1 transportation | 0.79 | 0.64 | 0.36 | | 0. |
| DCAutilisation | | | | | 0.52 | DCAutilisation | | | | | 0. |
| DCAhours | | | | | 963 | DCAhours | | | | | 17 |
| Cat A Performance | | | | | 79% | Cat A Performance | | | | | 85 |
| % of contract | | | | | 3.80% | % of contract | | | | | 6.8 |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Waisali | Category A | Category B | Category C | Urgent / Routine | Total | Wolverhamptor | Category A | Category B | Category C | Urgent / Routine | Tot |
| Waisali | Category A | Category B | Category C | Urgent / Routine | Total | Wolverhamptor | Category A | Category B | Category C | Urgent / Routine | Tot |
| <u>Waisali</u> Urban | Category A | Category B 303 | Category C 143 | Urgent / Routine 50 | Total 738 | Wolverhamptor | Category A | Category B 310 | Category C 137 | Urgent / Routine 71 | Tot 75 |
| <u>Walsall</u> Urban Semi Urban | Category A 242 10 | Category B 303 13 | Category C 143 6 | Urgent / Routine 50 2 | Total 738 31 | Wolverhamptor Urban Semi Urban | 2 Category A | Category B 310 | Category C 137 | Urgent / Routine 71 | Tot 75 |
| <u>Walsali</u> Urban Semi Urban Rural | Category A 242 10 | Category B 303 13 | Category C 143 6 | Urgent / Routine 50 2 | Total 738 31 | Wolverhamptor Urban Semi Urban Rural | 2 Category A 232 5 | Category B 310 6 | Category C 137 3 | Urgent / Routine 71 1 | Tot 75 |
| Walsall Urban Semi Urban Rural RRV utilisation | Category A 242 10 | Category B 303 13 | Category C 143 6 | Urgent / Routine 50 2 | Total 738 31 0.33 | Wolverhamptor Urban Semi Urban Rural RRV utilisation | 2 Category A 232 5 | Category B 310 6 | Category C 137 3 | Urgent / Routine 71 1 | Tot 75 15 0.3 |
| Walsall Urban Semi Urban Rural RRV utilisation RRV hours | Category A 242 10 | Category B 303 13 | Category C 143 6 | Urgent / Routine 50 2 | Total 738 31 0.33 841 | Wolverhamptor Urban Semi Urban Rural RRV utilisation RRV hours | Category A 232 5 | Category B 310 6 | Category C 137 3 | Urgent / Routine 71 1 | Tot 75 15 0.3 73 |
| Walsall Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance | Category A 242 10 0.98 | Category B 303 13 | Category C 143 6 | Urgent / Routine 50 2 | Total 738 31 0.33 841 0.83 | Wolverhamptor Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance | 2 Category A 232 5 0.97 | Category B 310 6 0.84 | Category C 137 3 0.51 | Urgent / Routine 71 1 | Tot 75 1! 0.3 73 0.8 |
| Walsall Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 transportation | Category A 242 10 0.98 0.79 | Category B 303 13 0.85 0.85 | Category C 143 6 | Urgent / Routine 50 2 | Total 738 31 0.33 841 0.83 0.63 | Wolverhamptor Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation | Category A 232 5 0.97 0.79 | Category B 310 6 0.84 0.64 | Category C 137 3 3 | Urgent / Routine 71 1 | Tot 75 15 0.3 73 0.8 |
| Walsall Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation | Category A 242 10 0.98 0.79 | Category B 303 13 0.85 0.64 | Category C 143 6 0.52 0.36 | Urgent / Routine 50 2 | Total 738 31 0.33 841 0.83 0.63 0.52 | Wolverhamptor Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation | Category A 232 5 0.97 0.79 | Category B 310 6 0.84 0.64 | Category C 137 3 3 0.51 0.34 | Urgent / Routine 71 1 | Tot 75 0.3 73 0.8 0.6 |
| Walsall Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 DCA AS1 otcansportation DCA utilisation DCA hours | Category A 242 10 0.98 0.79 | Category B 303 13 0.85 0.64 | Category C 143 6 0.52 0.36 | Urgent / Routine 50 2 | Total 738 31 0.33 841 0.83 0.63 0.52 1228 | Wolverhamptor Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA hours | Category A 232 5 0.97 0.79 | Category B 310 6 0.84 0.64 | Category C 137 3 3 0.51 0.34 | Urgent / Routine 71 1 | 75 75 1! 0.3 73 0.8 0.6 0.6 122 |
| Waisail Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA hours CA hours Cat A Performance | Category A 242 10 0.98 0.79 | Category B 303 13 0.85 0.64 | Category C 143 6 0.52 0.36 1 1 1 1 1 1 1 1 1 | Urgent / Routine 50 2 | Total 738 31 0.33 841 0.83 0.63 0.63 0.52 1228 85% | Wolverhampton Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA hours Cat A Performance | Category A 232 5 0.97 0.79 | Category B 310 6 0.84 0.64 | Category C 137 3 3 0.51 0.34 | Urgent / Routine 71 1 | Tot 75 0.3 73 0.8 0.6 0.5 122 844 |
| Walsall Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 attendance DCA AS1 ot AS1 attendance DCA AS1 AS1 attendance DCA AS1 AS1 attendance DCA AS1 AS1 attendance DCA AS1 AS1 attendance DCA AS1 AS1 AS1 AS1 AS1 AS1 AS1 AS1 AS1 AS1 | Category A 242 10 0.98 0.79 | Category B 303 13 0.85 0.64 0.64 | Category C 143 6 0.52 0.36 1 1 1 1 1 1 1 1 1 | Urgent / Routine | Total 738 31 0.33 841 0.83 0.63 0.52 1228 85% 5% | Wolverhamptor Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA utilisation DCA hours Cat A Performance % of contract | Category A 232 5 0.97 0.79 | Category B 310 6 0.84 0.64 | Category C 137 3 0.51 0.34 1 1 1 1 1 1 1 1 1 | Urgent / Routine 71 1 | Tota 750 15 0.3 73: 0.8 0.6 0.5 122 849 4.80 |



STAFFORDSHIRE

| <u>North</u> Staffordshir | Category A | Category B | Category C | Urgent / Routine | Total | <u>Stoke</u> | Category A | Category B | Category C | Urgent / Routine | Total |
|------------------------------|------------|---|---|---|--|---|--|--|------------|---------------------|-------|
| | | | | | | | | | | | |
| Urban | 131 | 177 | 105 | 56 | 469 | Urban | 237 | 321 | 165 | 92 | 815 |
| Semi Urban | | | | | | Semi Urban | | | | | |
| Rural | 23 | 31 | 19 | 10 | 83 | Rural | 7 | 10 | 5 | 3 | 25 |
| RRV utilisatio | n | | | | 0.28 | RRV utilisation | | | | | 0.3 |
| RRV hours | | | | | 565 | RRV hours | | | | | 930 |
| DCA AS1 attendance | 0.89 | 0.79 | 0.7 | | 0.8 | DCA AS1 attendance | 0.92 | 0.85 | 0.82 | | 0.86 |
| DCA AS1 transportatior | 0.65 | 0.57 | 0.47 | | 0.57 | DCA AS1 transportation | 0.63 | 0.58 | 0.56 | | 0.59 |
| DCAutilisatio | ı | | | | 0.47 | DCAutilisation | | | | | 0.51 |
| DCAhours | | | | | 940 | DCAhours | | | | | 1447 |
| Cat A Performance | | | | | 78% | Cat A Performance | | | | | |
| % of contract | | | | | 3.70% | % of contract | | | | | 5.80% |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | <u>South</u> Staffordshire | Category A | Category B | Category C | Urgent / Routine | Total | | | |
| | | | South Staffordshire | Category A | Category B | Category C | Urgent / Routine | Total | | | |
| | | L | South Staffordshire Irban | Category A 288 | Category B 394 | Category C 218 | Urgent / Routine 134 | Total 1034 | | | |
| | | L | South Staffordshire Irban iemi Urban | Category A 288 31 | Category B 394 42 | Category C 218 23 | Urgent / Routine 134 14 | Total 1034 110 | | | |
| | | L F | South Staffordshire Irban iemi Urban Rural | Category A 288 31 65 | Category B 394 42 89 | Category C 218 23 49 | Urgent / Routine 134 14 30 | Total 1034 110 233 | | | |
| | | L S F | South Staffordshire Irban eemi Urban Rural RRV utilisation | Category A 288 31 65 | Category B 394 42 89 | Category C 218 23 49 | Urgent / Routine 134 14 30 | Total 1034 110 233 0.3 | | | |
| | | L S F F F | South Staffordshire Irban eemi Urban Rural RRV utilisation RRV hours | Category A 288 31 65 | Category B 394 42 89 | Category C 218 23 49 | Urgent / Routine 134 14 30 | Total 1034 110 233 0.3 1250 | | | |
| _ | | U S F F F C a | South Staffordshire Irban eemi Urban eural RRV utilisation RRV hours DCA AS1 ttendance | Category A 288 31 65 0.89 | Category B 394 42 89 0.81 | Category C 218 23 49 0.75 | Urgent / Routine 134 14 30 | Total 1034 110 233 0.3 1250 0.82 | | | |
| | | L S F F F C a C tu | South Statfordshire Irban terni Urban terni Urban tern | Category A 288 31 65 0.89 0.69 | Category B 394 42 89 0.81 0.6 | Category C 218 23 49 0.75 0.51 | Urgent / Routine | Total 1034 110 233 0.3 1250 0.82 0.61 | | | |
| | | ע ג ג ג ג ג ג ג ג | South Statfordshire Irban emi Urban Rural RV utilisation RV hours OCA AS1 ttendance OCA AS1 ransportation DCA utilisation | Category A 288 31 65 0.89 0.69 | Category B 394 42 89 0.81 0.6 | Category C 218 23 49 0.75 0.51 | Urgent / Routine | Total 1034 110 233 0.3 1250 0.82 0.61 0.45 | | | |
| | | L S S R R R C L L L L L L L L L L L L L L L L | South Statfordshire | Category A 288 31 65 0.89 0.69 | Category B 394 42 89 0.81 0.6 | Category C 218 23 49 0.75 0.51 | Urgent / Routine | Total 1034 110 233 0.3 1250 0.82 0.61 0.45 2550 | | | |
| | | L S S R R R C a L U U U U C C R | South Statfordshire | Category A 288 31 65 0.89 0.69 | Category B 394 42 89 0.81 0.6 | Category C 218 23 49 0.75 0.51 | Urgent / Routine 134 14 30 | Total 1034 110 233 0.3 1250 0.82 0.61 0.45 2550 77% | | | |
| | | U S S F F F C C C C C F F 9 | South Statfordshire | Category A 288 31 65 0.89 0.69 | Category B 394 42 89 0.81 0.6 | Category C 218 23 49 0.75 0.51 | Urgent / Routine | Total 1034 110 233 0.3 1250 0.82 0.61 0.45 2550 77% 9.60% | | | |



COVENTRY AND WARWICKSHIRE

| <u>Coventry</u> | Category A | Category B | Category C | Urgent / Routine | Total | <u>Warwickshire</u> | Category A | Category B | Category C | Urgent / Routine | Total |
|---------------------------|------------|------------|------------|---------------------|-------|---------------------------|------------|------------|------------|---------------------|-------|
| | | | | | | | | | | | |
| Urban | 216 | 430 | 221 | 118 | 985 | Urban | 186 | 379 | 187 | 110 | 862 |
| Semi Urban | | | | | | Semi Urban | 31 | 63 | 31 | 18 | 143 |
| Rural | 2 | 4 | 2 | 1 | 9 | Rural | 68 | 138 | 68 | 40 | 314 |
| RRV utilisation | | | | | 0.39 | RRV utilisation | | | | | 0.3 |
| RRV hours | | | | | 833 | RRV hours | | | | | 1097 |
| DCA AS1 attendance | 0.96 | 0.86 | 0.74 | | 0.85 | DCA AS1 attendance | 0.93 | 0.81 | 0.72 | | 0.82 |
| DCA AS1 transportation | 0.7 | 0.59 | 0.5 | | 0.59 | DCA AS1 transportation | 0.69 | 0.54 | 0.45 | | 0.55 |
| DCAutilisation | | | | | 0.52 | DCAutilisation | | | | | 0.43 |
| DCAhours | | | | | 1640 | DCAhours | | | | | 2493 |
| Cat A Performance | | | | | 85% | Cat A Performance | | | | | 74% |
| % of contract | | | | | 6.20% | % of contract | | | | | 9.20% |
| | | | | | | | | | | | |



HEREFORDSHIRE, WORCESTERSHIRE AND SHROPSHIRE

| Herefordshire | Category A | Category B | Category C | Urgent / Routine | Total | Worcestershire | Category A | Category B | Category C | Urgent / Routine | Total |
|--|--|---|--|---------------------------------------|--|---|--|---|--|-------------------------------------|--|
| | | | | | | | | | | | |
| Urban | 46 | 58 | 27 | 27 | 158 | Urban | 286 | 399 | 169 | 155 | 1009 |
| Semi Urban | 25 | 33 | 15 | 15 | 88 | Semi Urban | 11 | 15 | 6 | 6 | 38 |
| Rural | 35 | 45 | 20 | 21 | 121 | Rural | 65 | 91 | 38 | 35 | 229 |
| RRV utilisation | | | | | 0.37 | RRV utilisation | | | | | 0.28 |
| RRV hours | | | | | 221 | RRV hours | | | | | 1296 |
| DCA AS1 attendance | 0.98 | 0.85 | 0.65 | | 0.85 | DCA AS1 attendance | 0.95 | 0.8 | 0.58 | | 0.81 |
| DCA AS1 transportation | 0.77 | 0.59 | 0.37 | | 0.61 | DCA AS1 transportation | 0.72 | 0.56 | 0.34 | | 0.57 |
| DCA utilisation | | | | | 0.39 | DCA utilisation | | | | | 0.47 |
| DCAhours | | | | | 805 | DCAhours | | | | | 2231 |
| Cat A Performance | | | | | 68% | Cat A Performance | | | | | 76% |
| % of contract | | | | | 2.80% | % of contract | | | | | 8.70% |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Shropshire | Category A | Category B | Category C | Urgent / Routine | Total | <u>Telford and</u> <u>Wrekin</u> | Category A | Category B | Category C | Urgent / Routine | Total |
| <u>Shropshire</u> | Category A | Category B | Category C | Urgent / Routine | Total | Telford and Wrekin | Category A | Category B | Category C | Urgent / Routine | Total |
| <u>Shropshire</u> Urban | Category A | Category B | Category C 35 | Urgent / Routine 39 | Total 223 | Telford and Wrekin Urban | Category A | Category B | Category C | Urgent / Routine 40 | Total 326 |
| <u>Shropshire</u> Urban Semi Urban | Category A 65 33 | Category B 84 43 | Category C 35 18 | Urgent / Routine 39 20 | Total 223 114 | Telford and Wrekin Urban Semi Urban | Category A 106 10 | Category B 126 12 | Category C 54 5 | Urgent / Routine 40 4 | Total 326 31 |
| Shropshire Urban Semi Urban Rural | Category A 65 33 68 | Category B 84 43 89 | Category C 35 18 37 | Urgent / Routine 39 20 41 | Total 223 114 235 | Telford and Wrekin Urban Semi Urban Rural | Category A 106 10 6 | Category B 126 12 7 | Category C 54 5 3 | Urgent / Routine 40 4 2 | Total 326 31 18 |
| Shropshire Urban Semi Urban Rural RRV utilisation | Category A 65 33 68 | Category B 84 43 89 | Category C 35 18 37 | Urgent / Routine 39 20 41 | Total 223 114 235 0.23 | Telford and Wrekin Urban Semi Urban Rural RRV utilisation | Category A 106 10 6 | Category B 126 12 7 | Category C 54 5 3 | Urgent/ Routine 40 4 2 | Total 326 31 18 0.27 |
| Shropshire Urban Semi Urban Rural RRV utilisation RRV hours | Category A 65 33 68 | Category B 84 43 89 | Category C 35 18 37 | Urgent / Routine 39 20 41 | Total 223 114 235 0.23 447 | Telford and Wrekin Urban Semi Urban Rural RRV utilisation RRV hours | Category A 106 10 6 | Category B 126 12 7 | Category C 54 5 3 | Urgent / Routine 40 4 2 | Total 326 31 18 0.27 450 |
| Shropshire Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 DCA AS1 | Category A 65 33 68 1.24 | Category B 84 43 89 | Category C 35 18 37 0.84 | Urgent / Routine 39 20 41 | Total 223 114 235 0.23 447 1.12 | Telford and Wrekin Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance | Category A 106 10 6 1.36 | Category B 126 12 7 7 1.26 | Category C 54 5 3 0.9 | Urgent/ Routine 40 4 2 | Total 326 31 18 0.27 450 1.23 |
| Shropshire Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation | Category A 65 33 68 1.24 0.72 | Category B 84 43 89 1.14 0.6 | Category C 35 18 37 0.84 0.84 | Urgent / Routine 39 20 41 | Total 223 114 235 0.23 447 1.12 0.60 | Telford and Wrekin Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation | Category A 106 10 6 1.36 0.77 | Category B 126 12 7 6 1.2 6 1.26 0.64 | Category C 54 5 3 0 0.9 0.39 | Urgent / Routine 40 4 2 | Total 326 31 18 0.27 450 1.23 0.64 |
| Shropshire Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation | Category A 65 33 68 1.24 0.72 | Category B 84 43 89 | Category C 35 18 37 0.84 0.84 | Urgent / Routine 39 20 41 | Total 223 114 235 0.23 447 1.12 0.60 0.4 | Telford and Wrekin Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation | Category A 106 10 6 1.36 0.77 | Category B 126 12 7 7 1.26 0.64 | Category C 54 5 3 0.9 0.39 | Urgent/ Routine 40 4 2 | Total 326 31 18 0.27 450 1.23 0.64 0.48 |
| Shropshire Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 transportation DCA utilisation DCA utilisation DCA hours | Category A 65 33 68 1.24 0.72 | Category B 84 43 89 1.14 0.6 | Category C 35 18 37 0.84 0.38 | Urgent / Routine 39 20 41 | Total 223 114 235 0.23 447 1.12 0.60 0.4 1551 | Telford and Wrekin Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA hours | Category A 106 10 6 1.36 0.77 | Category B 126 12 7 7 1.26 0.64 | Category C 54 5 3 0.9 0.39 | Urgent / Routine 40 4 2 | Total 326 31 18 0.27 450 1.23 0.64 0.48 918 |
| Shropshire Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA hours Cat A Pocformance | Category A 65 33 68 1.24 0.72 | Category B 84 43 89 1.14 0.6 | Category C 35 18 37 0.84 0.38 | Urgent / Routine 39 20 41 | Total 223 114 235 0.23 447 1.12 0.60 0.4 1551 65% | Telford and Wrekin Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA hours Cat A Performance | Category A 106 10 6 1.36 0.77 | Category B 126 12 7 0 1.26 0.64 | Category C 54 5 3 0.9 0.9 0.39 | Urgent / Routine 40 4 2 | Total 326 31 18 0.27 450 1.23 0.64 0.48 918 82% |
| Shropshire Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA utilisation DCA hours Cat A Performance % of contract | Category A 65 33 68 1.24 0.72 | Category B 84 43 89 1.14 0.6 | Category C 35 18 37 0.84 0.84 0.38 | Urgent / Routine 39 20 41 | Total 223 114 235 0.23 447 1.12 0.60 0.4 1551 65% 5.40% | Telford and Wrekin Urban Semi Urban Rural RRV utilisation RRV hours DCA AS1 attendance DCA AS1 transportation DCA utilisation DCA utilisation DCA hours Cat A Performance % of contract | Category A 106 10 6 1.36 0.77 | Category B 126 12 7 7 1.26 0.64 | Category C 54 5 3 0.9 0.39 | Urgent/ Routine 40 4 2 | Total 326 31 18 0.27 450 1.23 0.64 0.48 918 82% 3.50% |