North West Ambulance Service NHS
NHS Trust

Delivering the right care, at the right time, in the right place

NHS England

North West Divert

&

Deflection Policy

Version 6.0

Recommended by	NHS England (North West)
Approved by	NWAS Director of Operations Acute Trust Directors of Operations CCG Urgent Care Directors
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Responsible Director	NWAS Director of Operations
Responsible Manager (Sponsor)	Regional Business Manager
For use by	All Trust employees NHS Provider Emergency Departments CCG and NHS England

This policy is available in alternative formats on request. Please contact the Corporate Governance Assistant on 01204 498379

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1 INTRODUCTION

1.1 The North West region foot-print comprises a large geographical area covering over 5,400 square miles and a population of around seven million. Within this area, one regional Ambulance Service operates, covering twenty three Acute Trusts, incorporating twenty-seven Emergency Departments (ED); spanning a diverse landscape from the urban areas of Manchester and Liverpool, to more remote rural areas of Cumbria, Lancashire and Cheshire.

1.2 The purpose of this document is to ensure that the North West Ambulance Service (NWAS), Acute Providers, Clinical Commissioning Groups (CCGs) and NHS England have a clearly defined and consistent approach to ensure the timely handover of patients arriving at hospital by preventing or reducing delays. The overarching principle is the safety and dignity of our patients in every case.

1.3 This document does not replace individual organisational and health economy escalation and surge management processes, it is assumed that the divert actions within this document would only be requested after those processes had all been implemented and failed.

2 BACKGROUND AND CONTEXT

'The best practice standard for the timely clinical handover of a patient by an emergency ambulance crew to hospital staff is 15 minutes.' (Flory, 2012)

'Ambulance handover delays can be a symptom of system-wide issues, a mismatch of capacity and demand and inadequacy of patient flow. As such, handover delays must be recognised as a system wide responsibility. All organisations must co-operate to ensure effective working at the interfaces of healthcare organisations.' (Willett, 2017)

'Any patient physically on the hospital site should be regarded as under the care of the emergency department and should be booked into the department without delay; the clock should start ticking at that point. Patients should not wait in ambulances and should not be delayed being booked into the department…' (Baker, 2017)

2.1 There are a number of reasons why this 15 minute standard may not be achieved by a receiving hospital. This includes peaks in activity, availability of hospital staff and availability of a physical space to transfer the patient to within the ED. It could also be due to reduced flow through the ED admissions process due to capacity pressures within the wider Acute Trust. NWAS and Acute Trusts work together through local operational management teams to review, identify and resolve the causes of delays.

2.2 Ambulance delays at Acute Trusts, the deflection of Ambulances or the closure of a hospital ED can result in increased clinical risk to the patient.

Delays increase pressure on other local services, increasing waiting times for patients in both the hospital concerned and in neighbouring Trusts. In addition, there is the potential for these effects to impact on the NHS response capability to '999' calls, both by the ambulance service and also the emergency departments.

3 PRINCIPLES

3.1 The following principles have been established to form a basis for all capacity considerations and actions taken.

3.2 NHS Managers must ensure a consistent and evidence based approach to decision making is adopted, the Joint Decision Model (JDM) (Appendix 5) has been adopted by the NHS as an exemplar of good practice and should therefore be utilised.

3.3 NWAS and its health partners will have internal and health economy escalation procedures in place to ensure that early action is taken to prevent a crisis rather than reacting once it has occurred.

3.4 Patient safety and dignity takes priority over everything; all actions must be focused on providing patient access to definitive medical care.

3.5 There is a "No Divert or Deflection" agreement in place under normal levels of demand. Taking a patient to an alternative ED is only appropriate if:

- the Diverting unit is physically incapable of providing the right care and resuscitation facilities within a physically safe environment (Emergency Divert) or;
- demand and / or delays result in Ambulances queuing for significantly prolonged periods, **and** existing escalation and surge management plans have not been effective (Formal Divert).
- Any request to implement a Formal Divert must be formally investigated to prevent reoccurrence wherever possible (refer to 3.8).

3.6 No Acute Trust may close to life threatening '999' patients unless physically incapable of providing care and resuscitation facilities (Emergency Divert).

3.7 Any decision to divert patients from one Trust to another will involve consultation with the NWAS Strategic (Gold) Commander and will take place either in extreme circumstances (Emergency Divert) or following an agreement between requesting Acute Trust Executive, receiving Acute Trust Executive and the NWAS Strategic (Gold) Commander (Formal Divert).

3.8 Following the implementation of a Formal Divert, the requesting Acute Trust must complete an Incident Review within 48 hours and the findings of the

review discussed with the coordinating CCG who will determine any further action to take place.

For any Divert or Deflection request:

- The request should only be made when Trusts have implemented their escalation and surge management plans to the full without reducing the system pressures to a safe level.
- Under no circumstances should it be used to protect elective beds or, to avoid excessive waits in Emergency Departments.
- The request to divert or deflect patients from Acute Trusts, outside local established network arrangements, must be authorised by the Trust's Director of Operations or their Executive Director on-call.

4 DEFINITIONS

4.1 Borderline Deflection

4.1.1 The only patients impacted when a Borderline Deflection occurs will be located approximately halfway between the catchment areas of two or more Acute Trusts and NWAS resources will be advised to transport away from the affected site to a neighbouring Trust which is experiencing less pressures.

4.1.2 The NWAS on-call Tactical Commander must be contacted and appraised of the pressures experienced and the rationale for requesting the Borderline Deflection. The NWAS Tactical Commander must authorise any such requests.

4.1.3 The Regional Health Control Desk (RHCD) Coordinator in conjunction with the Emergency Operations Centre (EOC) may mobilise, if available, an NWAS Manager to the affected site to support NWAS staff and liaise directly with Acute Trust management team – whilst the NWAS Manager is en-route the Borderline Deflection may be instigated by the NWAS on-call Tactical Commander.

4.1.4 The Borderline Deflection does not include all patients – any patient whose treatment or where definitive care would be delayed by moving away from the affected site will be exempt and normal processes followed.

4.1.5 The RHCD Coordinator will inform the surrounding Acute Trusts to advise of the temporary instigation of a Borderline Deflection – any concerns raised must be escalated to the NWAS on-call Tactical Commander.

4.1.6 The RHCD Coordinator will confirm with the affected Trust that the local CCG have been made aware of handover pressures at Acute Trusts. Informing the CCG may be necessary during a challenging event or at the next available

opportunity i.e. the next working day. The decision when to inform the CCG/NHS England will be made by NWAS Strategic Commander (Gold) or Executive Director on-call.

4.2 Formal Divert

4.2.1 This type of action would be considered when an Acute Trust has exhausted all mitigating actions at theirs and their CCGs disposal to maintain flow through the ED and acute assessment routes. This should include full implementation of existing local health economy/SRG escalation and surge planning.

4.2.2 If handover of patients become prolonged, the RHCD Coordinator in conjunction with the EOC will mobilise an NWAS Manager where available; for example Ambulance Liaison Officer (ALO), Operations Manager or Advanced Paramedic (AP) to attend the affected unit for liaison with Trust staff and to support NWAS staff.

4.2.3 NWAS Managers on site must assess the likelihood and timescale of the situation improving by engaging with departmental managers, Bed Management teams and on-call Acute Trust managers and provide the RHCD Coordinator with this information. This information will be shared with local CCGs.

4.2.4 The pressures should be escalated by the RHCD Coordinator to NWAS Tactical Commander and provide contact details for the Acute Trust Tactical level managers so the options and mitigating actions available can be discussed and where appropriate sanctioned.

4.2.5 The Acute Trust affected must directly contact surrounding Trusts and seek agreement for a Formal Divert at an Executive level (See Appendix 2). Once this is confirmed a call should be made to the RHCD to request support and implementation. The RHCD will contact the NWAS Strategic Commander (Gold) to request authorisation.

4.2.6 This type of divert would not involve all types of patients – Red/Amber standbys **or any patient requiring resuscitation would be exempt.** For specific information regarding Major Trauma Centres please refer to Section 5.

4.2.7 Once NWAS receive the request to Divert, the NWAS Strategic Commander (Gold) must sanction and provide authorisation for the Divert to be implemented or rejected. This must be based on; current and predicted demand, cognisance given to: day of the week, time of day, period of the year; surrounding Acute Trust capacity and wider health economy position and logistics of the request – is it reasonable and clinically safe to transport patients from the requesting to the receiving site?

4.2.8 Should no surrounding Acute Trust be in a position to accept a Formal Divert:

(a) ***During normal working hours*** (i.e. Monday to Friday 9am to 5pm excluding bank holidays):
The Acute Trust should refer to the locally agreed system escalation plan and confirm with the CCG and partners any remaining actions to mitigate the situation. Where they agree that all possible local actions have been exhausted the Acute Trust or the CCG may contact the NHS England sub-regional 1st on-call for the appropriate NHS England on-call team to assess the situation and decide upon the most appropriate way forward.

(b) ***Outside normal working***:
The Acute Trust should inform the co-ordinating CCG of their position via the on-call system for information and guidance, following which the Acute Trust may contact the NHS England sub-regional 1st on-call for the appropriate NHS England on-call team to assess the situation and decide upon the most appropriate way forward.

If divert arbitration is required, and the Trust has confirmed that a Serious Operational Issue has been declared the 1st on call will then inform and support the NHS England AT 2nd on call to assess and resolve the situation, where possible.

4.2.9 An Incident Review must be completed following any agreed Formal Divert and forwarded to the coordinating CCG within 48 hours.

4.2.10 Should no surrounding Acute Trust be in a position to accept a Formal Divert, the coordinating CCG may contact the NHS England sub-regional 1st on-call for the appropriate NHS England on-call team to assess the situation and decide upon the most appropriate way forward. The Acute Trust and CCG must be in agreement that all possible local actions have been exhausted. If divert arbitration is required, and the Trust has confirmed that a Serious Operational Issue has been declared the 1st on call will then inform and support the NHS England AT 2nd on call to assess and resolve the situation, where possible.

4.2.11 The declaration of a Serious Operational Issue enables the wider system to adopt a command & control methodology and seek to support the Acute Trust where it has been unable to reach local agreement with its peers. It is expected that Trusts would be able to adopt internal processes and actions as required to effectively manage the presenting situation.

4.3 **Emergency Divert**

4.3.1 The only incidence where an immediate divert would be invoked would be during significant infrastructure events. Where the ED is **physically incapable** of providing clinical care and resuscitation facilities within a safe environment, examples include; fire, flood, infrastructure failure, electrical failure, actual or potential violent events.

4.3.2 **This type of action would involve all categories of patients.**

4.3.3 This type of action can be authorised by any NWAS Manager due to the immediacy of the situation.

4.3.4 All ambulance resources whether at the scene of an incident or en-route to the ED will be re-routed to the next nearest ED with appropriate treatment facilities to accommodate the patient.

4.3.5 This action will remain in place until the affected Trust have confirmed with NWAS that they are in a position to accept patients in a safe environment with appropriate treatment facilities.

4.3.6 The responsible NHS England sub-regional on-call will contact their counterparts in neighbouring areas if pressures are cross border but will only advise the NHS England (North) if mutual aid is required outside the North West.

4.3.7 The RHCD Coordinator in coordination with the EOC Duty Manager will mobilise an NWAS Manager to the affected department/Trust to support any NWAS staff on-site and directly liaise with Acute Trust management team.

4.3.8 An Emergency Divert will be subject to a de-briefing and review process in place for such events. The Acute Trust and CCG would be expected to conduct a health system debrief as early as is practicable. NHS England would ensure a wider debrief with all affected parties took place within 14 days and a report produced within 21 days.

5 MAJOR TRAUMA SYSTEM

5.1 In the North West, five major trauma systems have been established covering the adult populations of Lancashire and South Cumbria, Cheshire & Mersey, North Cumbria, Greater Manchester and a separate children's network.

5.2 Only designated Major Trauma Centres (MTCs) and Trauma Units (TUs) are able to provide the specialist care required for someone that has suffered major trauma, which may mean crews have to bypass the local ED.

5.3 Due to the limited number of MTCs/TUs across the North West, only an emergency divert can be considered.

5.4 However, if the MTC is part of a collaborative, then both a Formal Divert and Borderline Deflection may be considered on the understanding that there is agreement from the other centres to accept all pathfinder positive patients. This must be accompanied by a robust governance arrangement and the SUI process followed.

5.5 The NWAS Trauma Cell will monitor activity going into MTCs/TUs across the region and take necessary action, in collaboration with the NWAS on-call structure and the RHCD, where influxes of incidents have been experienced within one area.

6 MATERNITY SERVICES

6.1 Maternity Services across the region also experience increases in both demand and activity, and consequently see capacity pressures across their units.

6.2 Although this document describes actions predominantly involving Acute Trusts ED's, the same principles must be applied to any requests for the deflection or diverting of patients away from the normal receiving Maternity department.

6.3 In summary:

- The requesting Maternity Service must seek support from one or more receiving Unit – at an Executive to Executive level.
- Once this is confirmed a call should be made to the RHCD to request support and implementation.
- The RHCD Coordinator will contact the NWAS Strategic Commander (Gold) to request authorisation for implementation.
- The agreed action will retain the caveats of a Formal Divert – the arrangements will exclude any presentations of life threatening conditions to mother or baby and conditions which would fit into a standby category.
- The duration is likely to span longer than 60mins – and may be required for significantly longer – 8-12hrs for example.
- Should it be necessary, the NWAS crew transporting a patient under the above caveats will remain with the patient until a decision is made as to whether an onward transfer is required.

7 ROLES AND RESPONSIBILITIES

North West Ambulance Service

7.1 The NWAS RHCD and EOC Duty Manager will monitor NWAS resource time at hospital. The RHCD Coordinator will take action when there is a predicted or an actual increase in patient handover times.

7.2 The RHCD Coordinator will liaise directly with Acute Trust ED and Bed Management teams to establish the capacity of individual receiving departments, building a picture of pressures actually or likely to impact on patient flow.

7.3 Where ambulance staff identify a delay and recognise that they will not be in a position to provide a clinical handover of their patient within a reasonable time, they will contact the RHCD or relevant NWAS EOC to report the delay.

7.4 The Escalation process is described in Appendix 1, and details the requirement to ensure the requesting Trust confirms that mitigating actions have been explored and exhausted (Appendix 3).

7.5 NWAS will escalate to the relevant NHS England sub-regional on-call when divert arbitration is required and the provider Trust has declared a Serious Operational Issue (therefore reportable as a Serious Untoward Incident (SUI) and requires a full Root Cause Analysis (RCA)).

NWAS Attending Crews

7.6 All crews are expected to actively seek to handover their patients as soon as they enter the ED, or other receiving location, with a clinical handover being achieved within 15 minutes of arrival notification.

7.7 No patient will be left on a trolley without an appropriate clinical handover to Acute Trust staff in the ED or in any other receiving location.

7.8 As soon as clinical handover has taken place, crews are expected to make their vehicle and equipment ready and clear with the EOC. When and where possible, crews should move away from the ED entrance and wait for further instructions from EOC.

7.9 A contact call will be made from NWAS crews or attending NWAS managers to the RHCD if clinical handover at the Acute Trust cannot be achieved within 15-30 minutes from notification or handover is not likely to take place within 30 minutes of the patient arriving by Ambulance in the department.

Acute Trusts

7.10 Any Acute Trust facing particular challenges must keep NWAS regularly informed through the RHCD and ensure their CCG is informed of current pressures in a timely manner i.e. as early as possible during the day.

7.11 All existing escalation and surge plans and mitigating actions (Appendix 3) must have been implemented and options exhausted before considering a Formal Divert request.

7.12 The Acute Trust affected must directly contact surrounding Trusts and seek agreement to a Formal Divert at an Executive level (See Appendix 2).

7.13 Should no surrounding Acute Trust be in a position to accept a Formal Divert, the coordinating CCG executive on-call can contact the NHS England sub-regional 1st on-call for the appropriate NHS England Team to assess the situation and decide upon the most appropriate way forward. Should a Formal Divert be required then the Acute Trust executive on-call will need to declare a Serious Operational Issue for their Trust and have the formal support of their CCG on-call.

7.14 An Incident Review must be completed following any agreed Formal Divert and forwarded to the coordinating CCG within 48 hours.

Clinical Commissioning Groups (CCGs)

7.15 CCGs across the region operate 24/7 on-call system capability as part of their Category 2 Responder duties. This policy does not impact on that Category 2 status.

7.16 CCGs will have whole system/System Resilience Group (SRG) escalation plans that offer assistance where appropriate to affected Acute Trusts when specified triggers are reached. CCGs should work with the Acute Trust to ensure that all available escalation capacity and remedial actions have been exhausted before a Formal Divert is requested by an Acute Trust.

7.17 Where a Formal Divert, or Emergency Divert has been requested the coordinating CCG will ensure their provider investigates the root causes within 48 hours to prevent re-occurrence. The resulting report will be shared with the respective System Resilience Group (SRG), the receiving SRGs and NHS England sub-region when completed.

NHS England Teams

7.18 The NHS England sub-region will liaise with NWAS to monitor the frequency of deflections and diverts across their system and discuss with CCGs as appropriate.

7.19 If divert arbitration is required, and the Trust has declared a Serious Operational Issue supported by their CCG, the NHS England 1st on-call will inform and support the NHS England 2nd on call to resolve the situation, where possible.

7.20 Should the location of the affected Trust mean a potential impact on a Trust from a neighbouring NHS England area, the host NHS England on-call team must contact the adjacent NHS England on-call team in the potential receiving Trust area under mutual aid.

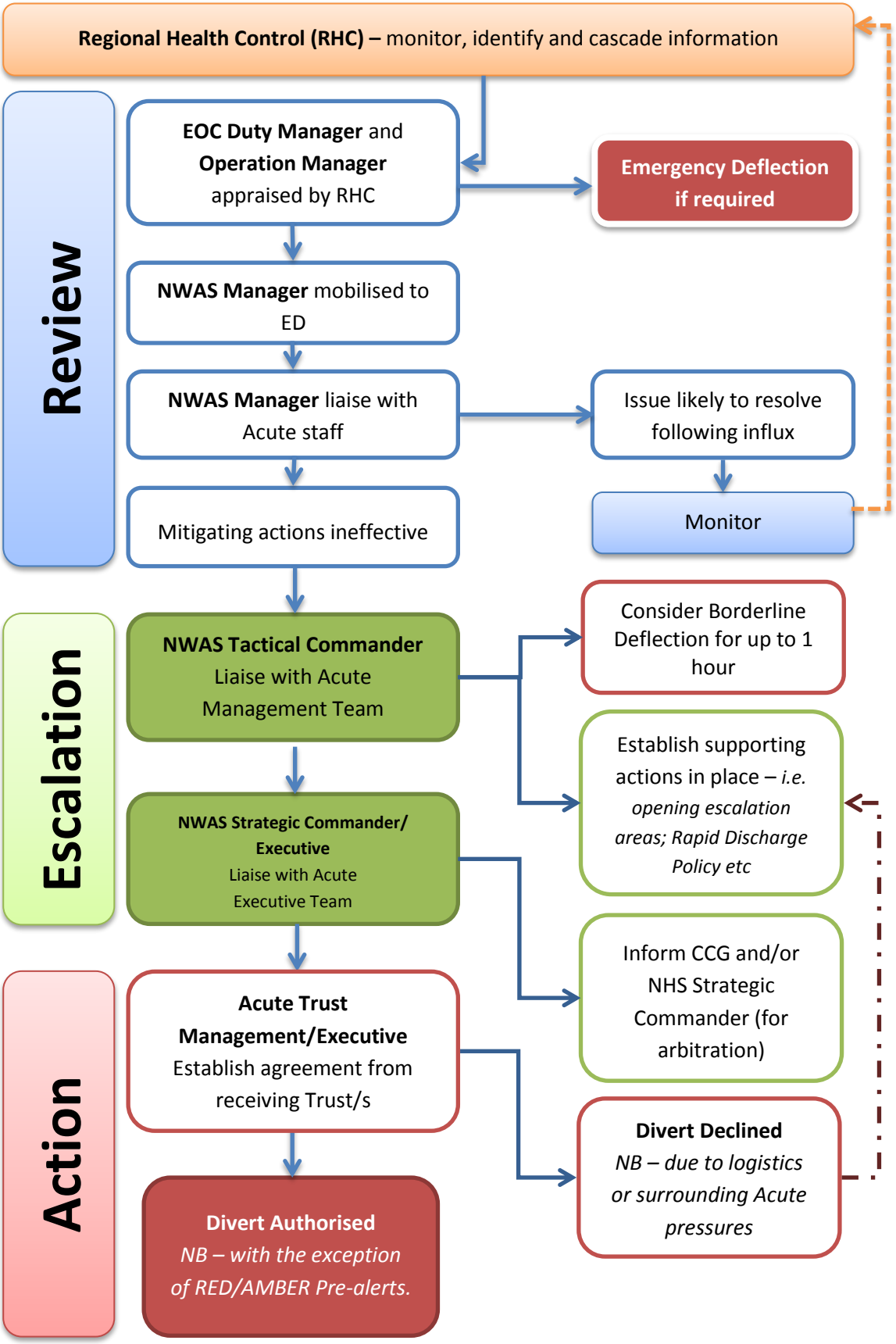
7.21 The NHS England 2nd on-call will, if appropriate, advise their Local Resilience Forum partners if a Serious Operational Issue has been declared and it is appropriate for multi–agency partners to be informed and/or involved.

7.22 The NHS England 2nd on-call will also advise NHS England (North) 1st on-call if a Serious Operational Issue has been declared, or if mutual aid is required outside of the North West, either on a regional or national level.

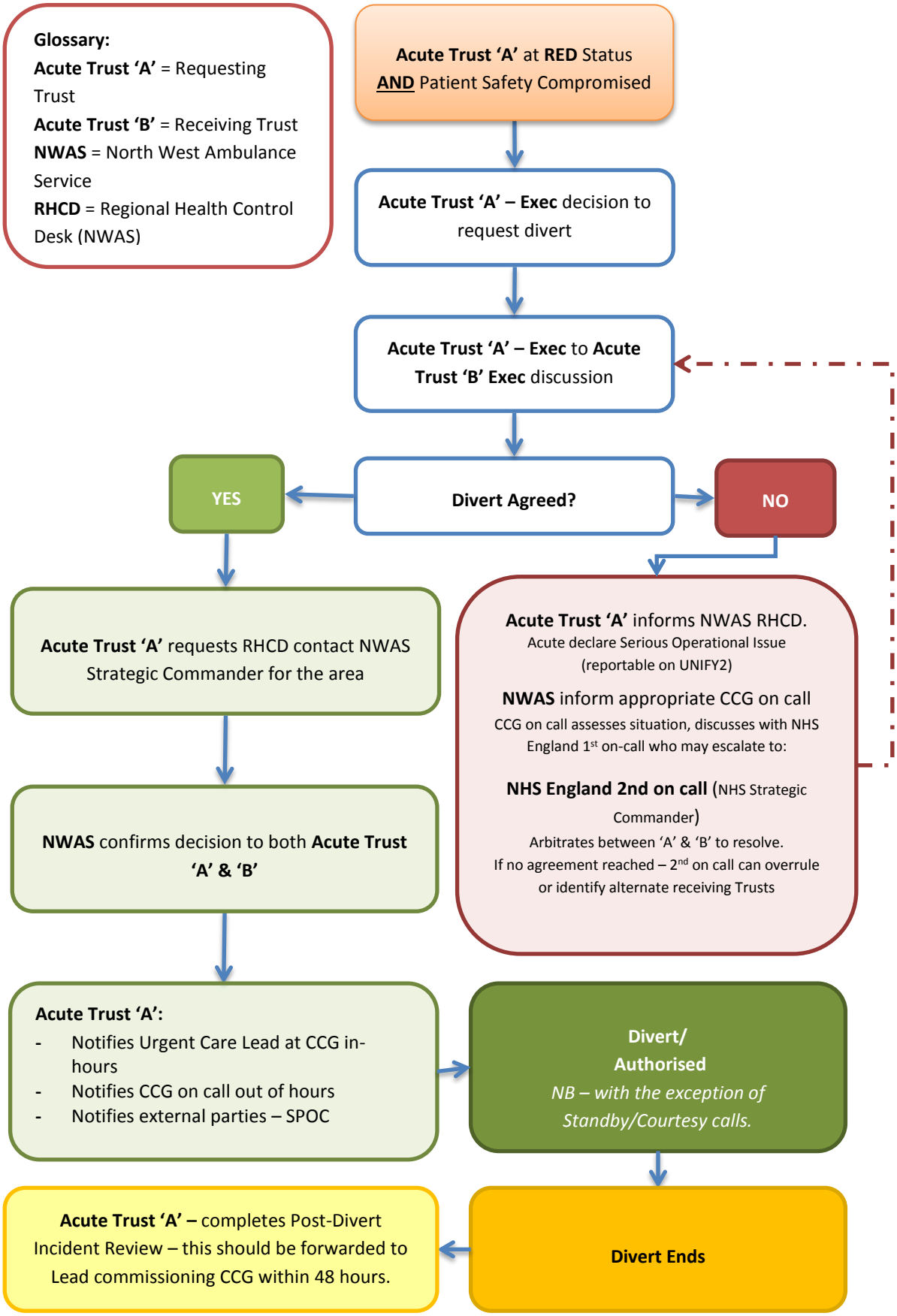
NHS England Regional Team

7.23 NHS England (North) will only be involved in hospital divert arrangements should the need arise for consideration of mutual aid from outside the North West or if regional specialist communications advice and support is required.

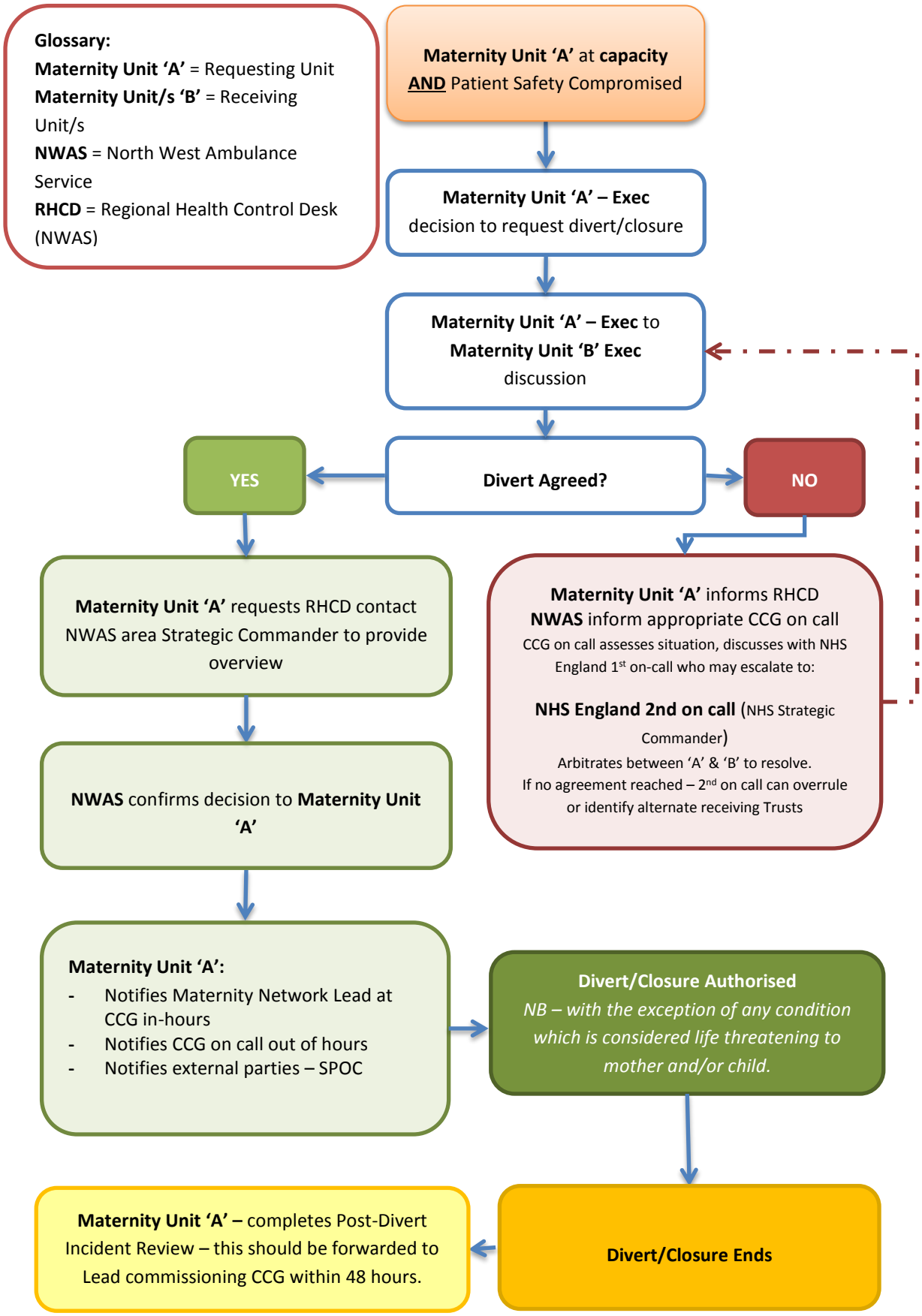
Appendix 1 – NWAS Escalation Flow Chart



Appendix 2 – Acute Trust Divert Flowchart



Appendix 3 – Acute Trust Maternity Divert/Closure Flowchart



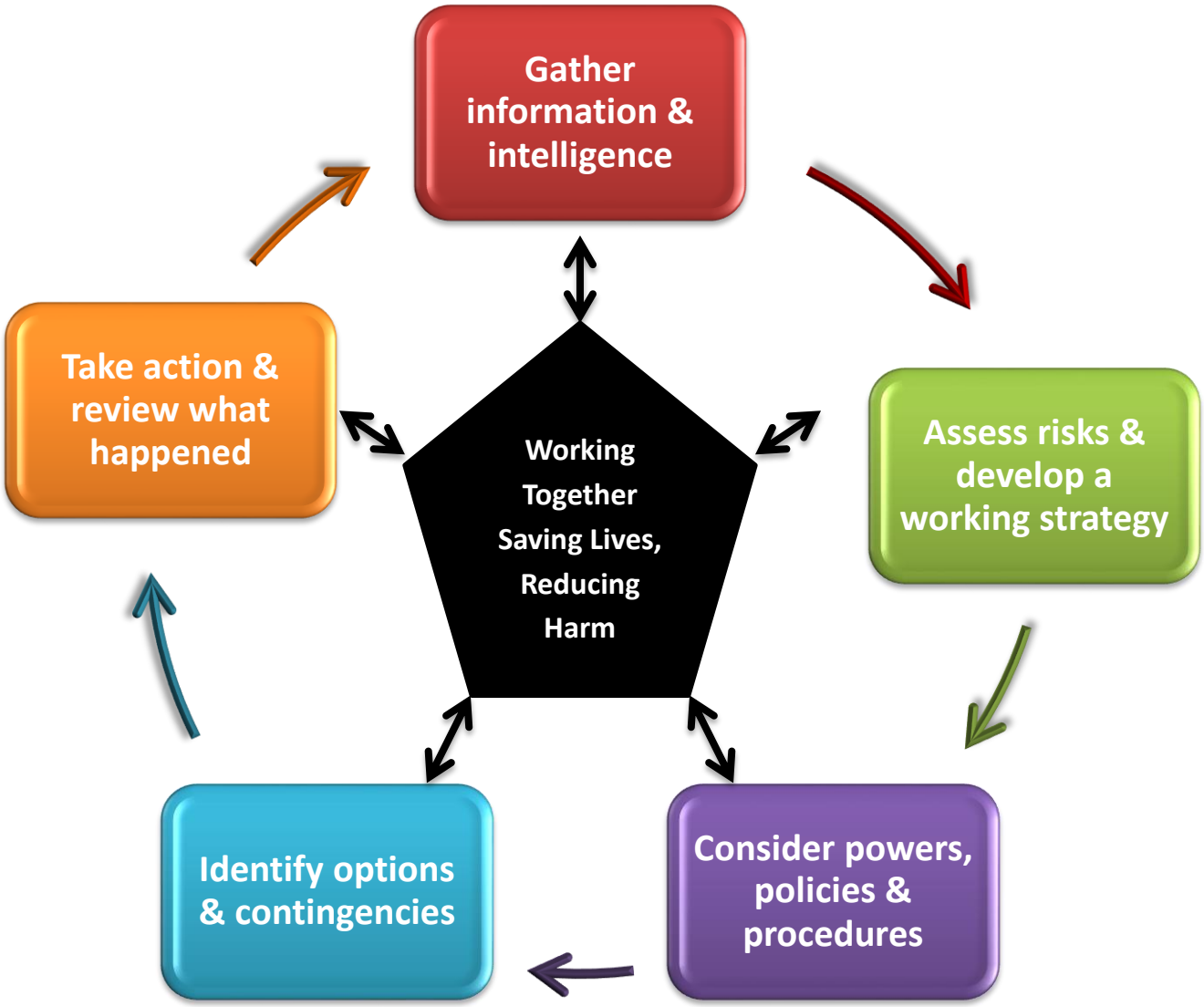
Appendix 4 – Actions & Considerations for NWAS Managers

Ambulance Divert / Deflection Review

Name:		**Date:**	
Role:		**Time:**	

Ambulance Service (NWAS and surrounding Ambulance Trusts):	**Response**
How many Ambulances are delayed handing over?	
How long have they been there – longest wait?	
Have NWAS positioned/mobilised a Manager to the site?	
Who have NWAS liaised with on-site?	
How long is the issue likely to last?	
Acute Trusts:	
How are electives being managed? Has the Trust cancelled electives?	
How many patients in ED and how many awaiting admission?	
All escalation and surge plans have been activated and available capacity created in the health economy	
Number of beds potentially coming up in the next four to twelve hours	
What is the position on healthcare acquired infections – are there any wards with restricted admission?	
Questions for Attending ALO/Ops Manager/SP/AP	
ED Capacity – any cubicles available etc.	
ED staffing – enough staff of right type (skill mix), Doctors availability	
Increase in ED self-presenters?	
Waiting time to see a Doctor in ED	
Any ED Patients breached (4-hour standard)	
Overall Bed State of hospital	
Numbers of actual or potential discharges – any waiting for NWAS?	

Appendix 5 – Joint Decision Model



The Joint Decision Model (JDM) (extracted from JESIP Doctrine)

Appendix 6 – Contact Directory

NWAS			
Regional Health Control	**0345 1130099**		regionalhc@nwas.nhs.uk
HOSPITAL	**A/E**	**BED MANAGER**	**SWITCH**
Blackpool	01253 303 496	01253 300 000	01253 300 000
Chorley	01257 245 219	01257 261 222	01257 261 222
Cumberland	01228 814 409	01228 814 103	01228 523 444
Furness	01229 491 043	01229 870 870	01229 870 870
Ormskirk (UCC)		01695 547 471	01695 577 111
Blackburn	01254 734 023	01254 732 098	01254 263 555
Lancaster	01524 583 001	07768 718 468	01524 65944
Preston	01772 522 348	01772 523 898	01772 716 565
West Cumberland	01946 523 278	01946 693 181	01946 693 181
Bolton	01204 390 393	01204 390 390	01204 390 390
Fairfield	0161 778 2343	0161 778 2537	0161 764 6081
Salford Royal (Hope)	0161 206 1340	0161 206 4598	0161 789 7373
Manchester Royal	0161 276 6160 0161 276 8554	0161 276 1234	0161 276 1234
North Manchester	0161 720 2459	0161 627 8471	0161 795 4567
Rochdale (UCC)		0161 627 8471	01706 377 777
Oldham	0161 627 8991	0161 627 8471	0161 624 0420
Stepping Hill	0161 419 4110	0161 483 1010	0161 483 1010
Tameside	0161 331 6251	0161 331 6000	0161 331 6000
Trafford	0161 746 2725	0161 748 4022	0161 748 4022
Wigan (Royal Albert & Edward)	01942 822 429	01942 244 000	01942 244 000
Wythenshawe	0161 291 6041	0161 998 7070	0161 998 7070
Aintree	0151 529 2324	0151 529 6247	0151 525 5980
Arrowe Park	0151 604 7203	0151 604 7160	0151 678 5111
Chester	01244 365 227	01244 365 900	01244 365 000
Leighton	01270 612 159	01270 255 141	01270 255 141
Liverpool Royal	0151 706 2050	0151 706 2000	0151 706 2000
Macclesfield	01625 661 452	01625 421 000	01625 421 000
Southport	01704 704128	01704 547471	01704 547471
Warrington	01925 662 010	01925 662789	01925 635 911
Whiston	0151 430 1313	0151 426 1600	0151 426 1600

Appendix 7 – Change Record Form

Version	Date of change	Date of release	Changed by	Reason for change
x.1	02 July 2012		A Jackson	Document creation
x.2	25 July 2012		A Jackson	Amendment to body of text
x.3	8 August 2012		A Jackson	Following review and comments by G Blezard
x.4	5 September 2012		A Jackson	Following review and comments by Graham Lovatt
x.5	3 December 2012		A Jackson	Update regarding Trauma Network from Salman Desai – changes to body of text – (AJ)
x.6	15 March 2013		A Jackson	Further update on Trauma Network (SD)
x.7	25 March 2013		A Jackson	Following suggestions on new Health structure (SD)
1.0	20 May 2013		A Jackson	Approved by DC
1.1	10 October 2013		A Jackson	Following review by Jane Keenan Merseyside LCCG
1.2	15 October 2013		A Jackson	Following review by NHS England (Greater Manchester) Colin Kelsey
1.3	23 October 2013		A Jackson	Following review by NHS England (Merseyside) Steve Corrigan
1.4	23 October 2013		A Jackson	Following review by Jane Keenan Merseyside Coordinating CCG
1.5	30 October 2013		A Jackson	Following review by NW NHS England EPRR Leads
1.6	31 October 2013		A Jackson	Following further NHS England AT review
1.7	4 November 2013		A Jackson	Following comments by NHS England AT (GM)
1.8	19 November		C Kelsey	Collating comments across NW Area Team discussions with providers and CCGs.
2.0	20 November 2013		A Jackson	Final Version
2.1	29 November 2013	1 December 2014	A Jackson	Revised Final Version following further review by Senior AT colleagues
2.2	18 August 2014		A Jackson	Rewording and updating of contact details and terminology
2.3	17 September 2014		A Jackson	Confirmation from NHSE AT (GM) Colin Kelsey re: terminology.
2.4	28 September 2014		A Jackson	Insertion of a Maternity Unit Flowchart
2.5	2 June 2015		A Jackson	Following comments from NHSE AT (GM) Colin Kelsey
2.6	06/07/2015		A Jackson	Following comments from NWAS S Ellis.
2.7	07/07/2015		A Jackson	Following comments by NHSE C Kelsey
2.8	07/07/2015		A Jackson	Following review by S Ali re: Maternity Section and AJ changed Format
2.81	14/07/2015		A Jackson	Following review and comment by NHSE (C&M) J Deacon
2.82	14/07/2015		A Jackson	Update to Joint Decision Model (JESIP)
2.83	07/08/2015		A Jackson	Formatting and text changes.
2.84	13/08/2015		C Kelsey	Change to NHSE terminology
2.85	14/09/2015		A Jackson	Following initial comments by CCGs in C&M
2.86	01/10/2015		A Jackson	Following final comments from NHSE C&M
2.87	07/10/2015		A Jackson	Final comments received from commissioner and provider organisations.
2.88	27/10/2015		A Jackson	Further comments received from commissioner and provider organisations.
3	30/10/2015	4/11/2015	A Jackson	Final Revised Version
4	5/5/2017	05/05/17	A Jackson	Extended Date of Review
4.1	08/05/2018		A Jackson	Annual Review
5.0	09/05/2018	09/05/2018	A Jackson	Final revised Version
5.1	30/05/2018		A Jackson	Amendment to Appendix 2 Flow Chart
5.2	07/01/2019		A Jackson	Annual Review

Appendix 8 – Glossary

EOC	Emergency Operations Centre
NWAS	North West Ambulance Service
NHS AT	NHS Area Team
CCG	Clinical Commissioning Group
RHCD	Regional Health Control Desk
ROCC	Regional Operational Coordination Centre

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