London Ambulance Service NHS
NHS Trust

# Winter and Flu Planning Framework

# 2009/10

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**CONFIDENTIAL**

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## Appendices

## 1. Executive Summary

1.1 The Winter and Flu Planning Framework 2009/10 for the London Ambulance Service sets out to maintain optimum levels of service to service users across the capital by deploying, where necessary, innovative and different solutions to demand and capacity management.

1.2 The autumn and winter period of 2009/10 is likely to be different to others seen in recent years as a result of a high likelihood of a resurgence of swine flu. Planning assumptions in this regard indicate a fifteen week pandemic wave (the second in the UK) during which activity for health services will peak during weeks four to eight.

1.3 The London Ambulance Service NHS Trust has played a key role in the planning arrangements with ambulance services across the UK and this framework sets out the specific London arrangements for managing peaks in demand whilst at the same time experiencing a reduction in the capacity to deal with that rising demand.

1.4 Actions to increase available staffing, capacity management regimes and alternate ways of dealing with requests for emergency ambulances are at the heart of this framework and will where practicable, maintain a high level of emergency response to those patients in greatest need.

1.5 UK ambulance services are organisations that are structured so that virtually all available resources are routinely deployed to frontline services. Consequently there are few additional assets within organisations that can be released to provide additional capacity.

1.6 The national patient waiting time standards operated within ambulance trusts are very susceptible to subtle increases to demand and capacity. This framework recognises that vulnerability and sets out a series of considerations that if faced with the predicted impact of the second wave of pandemic flu during the autumn and winter period of 2009/10 will, where possible, maintain high levels of emergency ambulance cover across the capital.

1.7 The framework adopts existing principles for the management of short term increases in demand where this outstrips supply (capacity) and seeks to enhance these arrangements and ensure a whole system approach to protracted periods of unprecedented demand for our services.

1.8 The framework is shared with partners in the London health economy and has been the subject of assurance exercises from both NHS London (Strategic Health Authority) and the Department of Health.

## 2. Introduction

2.1 In common with ambulance services across England, the London Ambulance Service responds to an ever-increasing demand for their services during winter through a planned and structured approach to overall capacity planning. The London Ambulance Service has a Winter Plan and a Strategic and Operational Flu Plan in place. This document seeks to bring the various stands of each of these documents together to form one overarching document that will manage both general winter capacity issues and those associated with pandemic flu.

2.2 The winter of 2008/9 was the coldest for many years and also had some significant adverse weather events (in particular the snow in February 2009). This led to an unprecedented demand on ambulance services in the capital. This resulted in London Ambulance Service operating at REAP 4 for some days and the creation of new demand management opportunities.

2.3 There was a perception in some quarters that ambulance services in the round did not cope well with the winter of 2008/9. These concerns have carried forward into the planning for the coming winter of 2009/10, which will have the added dimension of pandemic flu.

2.4 The Ambulance Service Chief Executive Group (ACEG) has therefore decided on an enhanced strategic national approach to winter and flu planning for 2009/10 designed to ensure that all scenarios are adequately addressed in a collaborative manner, which affords a consistent national approach to rising pressure.

2.5 A programme of activity has therefore been put in place led by the National Ambulance Director DH, Peter Bradley which will produce a national planning framework for ambulance trusts across the UK which has been used to inform our local planning arrangements.

2.6 This London Ambulance Service Plan and its supporting appendixes provide the framework for winter and flu planning within London Ambulance Service. A separate, operational plan will deal solely with New Year's Eve.

2.7 Many of the arrangements in this framework appear extreme set against normal or accepted levels of demand. However, during the pandemic or during periods of sustained adverse weather it is possible that demand for emergency ambulance services will far outstrip supply for protracted periods and set against this context we will need to do many different things that we would not normally consider as reasonable. These actions are designed to protect patient care during times of extremis and are not designed to replace existing workforce and operational arrangements once the pandemic subsides. Our response to unprecedented demand over a prolonged period(s) will require us to be exceptionally flexible to meet these challenges.

## 3. Aims, Objectives and Strategic Intention

3.1 The aim of this plan is to integrate planning within the London Ambulance Service to manage and react to seasonal (winter) peaks in demand. It also incorporates our preparedness arrangements for responding to a resurgence of pandemic flu during the same period.

3.2 The objectives of the winter and flu planning framework for 2009/10 are to:

- Identify risks to LAS core functions through the assessment of planning assumptions and their likely impact to the trust;
- Ensure that appropriate and flexible contingencies are available to mitigate increases in demand and staff absence;
- Maintain appropriate levels of patient care against a backdrop of unprecedented demand and reduced capacity;
- Ensure a cohesive multi-agency collaborative approach to increases in demand and growing pressure across the health economy; and
- Provide robust business continuity arrangements across the trust.

3.3 The strategic intention of the trust during this period is to:

- Preserve and protect lives;
- Mitigate and minimise the impact of increases in the demand for ambulance Services to the wider NHS;
- Inform the public and maintain public confidence;
- Ensure sufficient assets are available to manage the increase in demand for core activities against a backdrop of reducing capacity to maintain service delivery;
- Work collaboratively with multi-agency partners to mitigate the impact of unprecedented increases in demand for health services; and
- Assist an early return to normality (new normality).

## 4. The National Planning Process

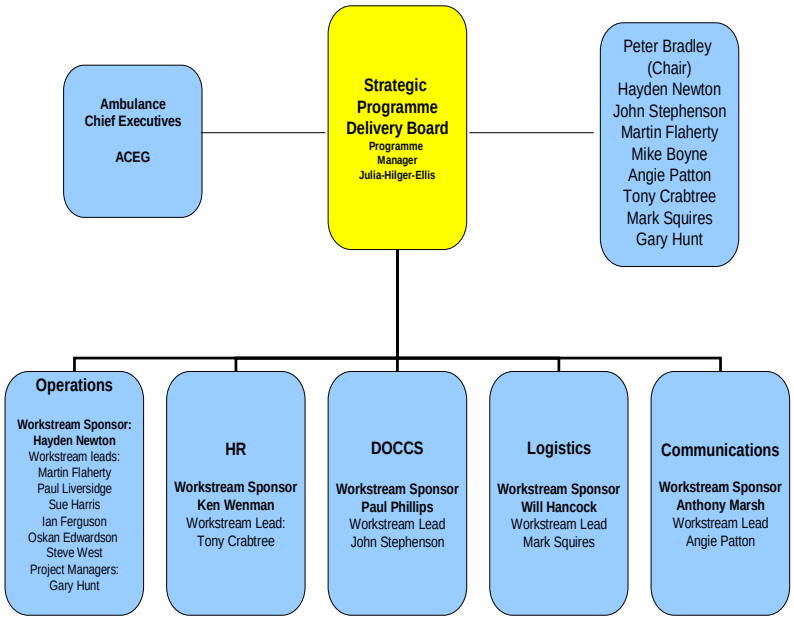
4.1 A National Planning Programme has been established under the principles of Managing Successful Programmes (MSP) and is designed to coordinate the multiple national work-streams which have each been sponsored by an Ambulance Trust CEO lead ensuring that they are complimentary and deliver defined outputs within tightly defined timescales. The programme also manages any significant interdependencies between the work-streams.

4.2 A programme brief was produced which provided a full and firm foundation for the initiation of the programme. It was the first product of the Programme, developed by the Programme Manager and Programme Executive and was required to authorise the start-up.

4.3 The brief set out the essential details of the Programme which delivered a robust National Ambulance Services Winter and Flu Planning Framework for 2009/2010 to manage capacity and capability of ambulance services allowing them to respond effectively to the expected increase in demand for services while managing staff absence levels higher than normal as a consequence of pandemic flu.

4.4 The programme was structured as set out below:

**Programme Management Arrangements for Winter/Pandemic Influenza**




N.B. Mike Boyne is part of the DH Implementation team around assurance & audit

## 5. Planning Assumptions for 2009/10

5.1 National and regional planning assumptions have indicated we should expect to see substantial increases in demand for ambulance services in:

a. 999 calls
b. Emergency responses (incidents)
c. Conveyance rates to Emergency Departments

5.2 Department of Health guidance setting out national planning assumptions for clinical attack rates are set out in Table 1 below. Table 2 includes additional data setting out high level planning assumptions.

| **Planning assumptions: potential effects of A(H1N1) infection for the general population** | |
|---|---|
| Clinical attack rate | Up to 30% of population |
| Peak clinical attack rate | Nationally: up to 6.5% of population per week |
| | Locally: up to 4.5% to 8% of population per week |
| Case complication ratio | Up to 15% of clinical cases |
| Case hospitalisation ratio | Up to 1% of clinical cases of whom 25% could require intensive care at any time |
| Case fatality ratio | Up to 0.1% of clinical cases |
| Peak absence rate (A(H1N1) only) | Up to 12% of workforce |

***Table 1***

| Assumption | Illustrative numbers, England | Data source for assumption |
|---|---|---|
| 30% of population will become symptomatic during a pandemic, and *of these symptomatic cases*: | Of the 51.9m people in England, roughly 15.5m will become symptomatic. And *of these 15.5m:* | SPI-M pandemic planning profiles |
| *15% will consult a GP* | Roughly 2.3m will consult a GP | SPI-M pandemic planning profiles |
| *6.9% will call an ambulance* | Roughly 1.1m will call 999 for an ambulance | London Ambulance Service; QSurveillance; NPFS |
| *4.0% will receive an emergency response at the scene* | Roughly 0.6m will receive an emergency response at the scene of the call to 999 | London Ambulance Service; QSurveillance; NPFS |
| *2.5% will require a conveyance from the scene* | Roughly 0.4m will be conveyed from the scene of the call | London Ambulance Service; QSurveillance; NPFS |
| *1% will require hospitalisation* | Roughly 0.2m will require hospitalisation | SPI-M pandemic planning profiles |

***Table 2***

5.3 Table 3 below sets out the numbers of cases that are likely as a result of the planning assumptions set out above.

| Week | Clinical Cases | GP Consults | Hospitalisation |
|---|---|---|---|
| 1 | 3,256 | 488 | 33 |
| 2 | 4,633 | 695 | 46 |
| 3 | 18,576 | 2,786 | 186 |
| 4 | 70,751 | 10,613 | 708 |
| 5 | 239,194 | 35,879 | 2,392 |
| 6 | 488,622 | 73,293 | 4,886 |
| 7 | 479,730 | 71,960 | 4,797 |
| 8 | 323,529 | 48,529 | 3,235 |
| 9 | 220,218 | 33,033 | 2,202 |
| 10 | 171,010 | 25,652 | 1,710 |
| 11 | 118,599 | 17,790 | 1,186 |
| 12 | 59,044 | 8,857 | 590 |
| 13 | 35,503 | 5,325 | 355 |
| 14 | 19,545 | 2,932 | 195 |
| 15 | 14,859 | 2,229 | 149 |
| Total activity | 2,267,070 | 340,061 | 22,671 |
| Peak week | 488,622 | 73,293 | 4,886 |
| as % of population | 30.0% | 4.5% | 0.3% |
| as % of clinical cases | 100.0% | 15.0% | 1.0% |

*Source: SPI-M consensus statement 28-9-09*

***Table 3***

5.4 Modelling undertaken at the Department of Health based on actual data from London Ambulance Service during the first wave of the current pandemic indicates a demand profile for incoming 999 calls as set out in figure 1 below, emergency ambulance responses (incidents) as set out in figure 2 below and ambulance conveyances to emergency departments in figure 3 below.

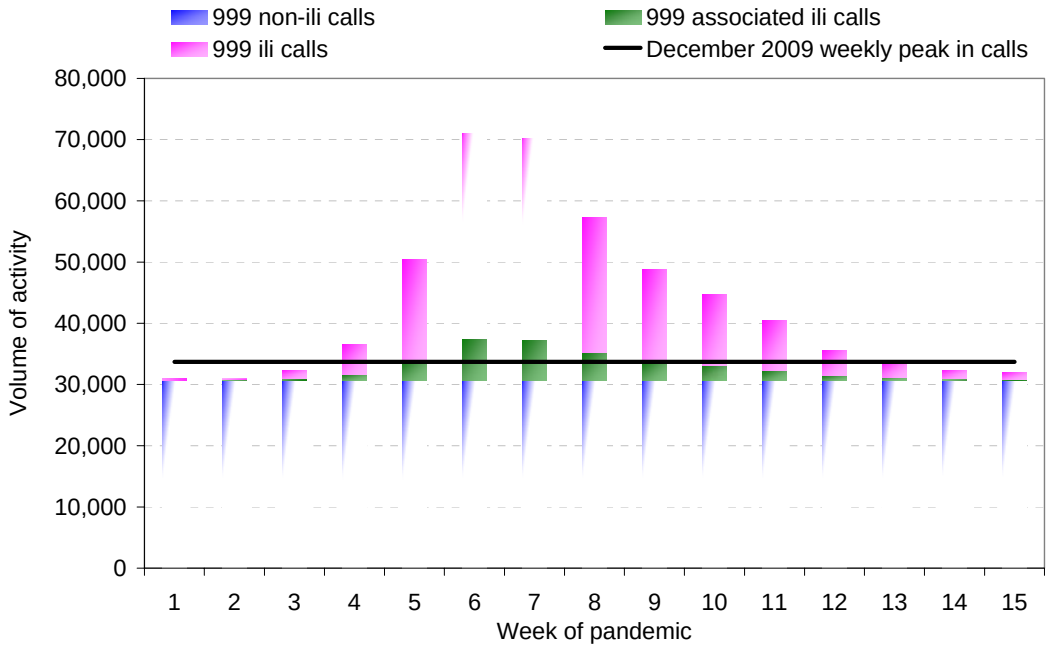



***Figure 1: incoming 999 calls***

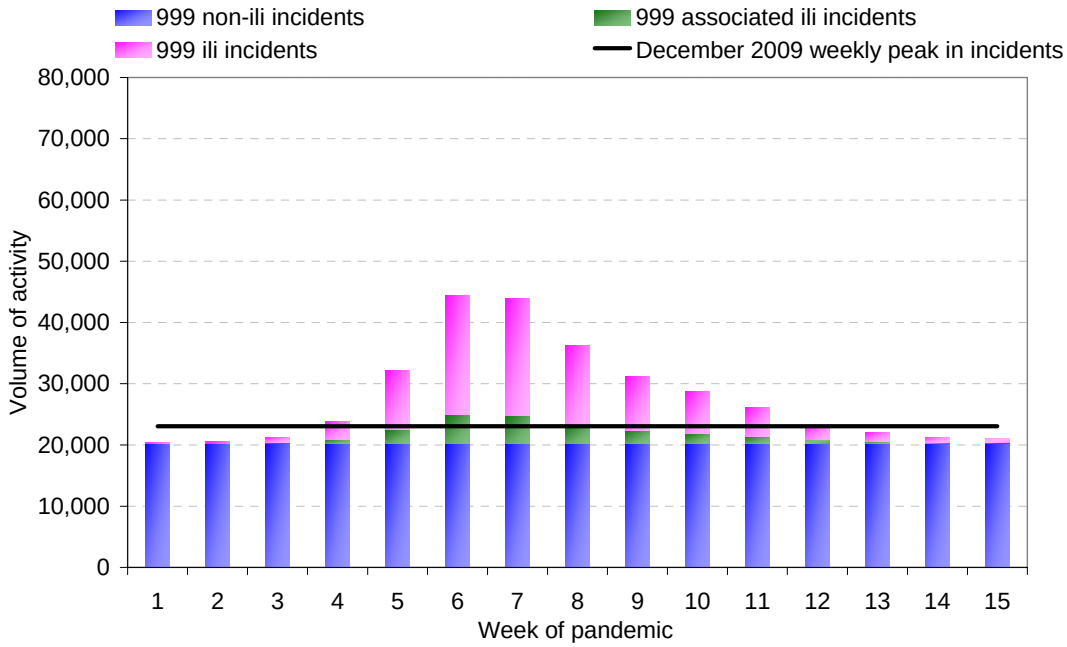



***Figure 2: emergency ambulance responses (incidents)***

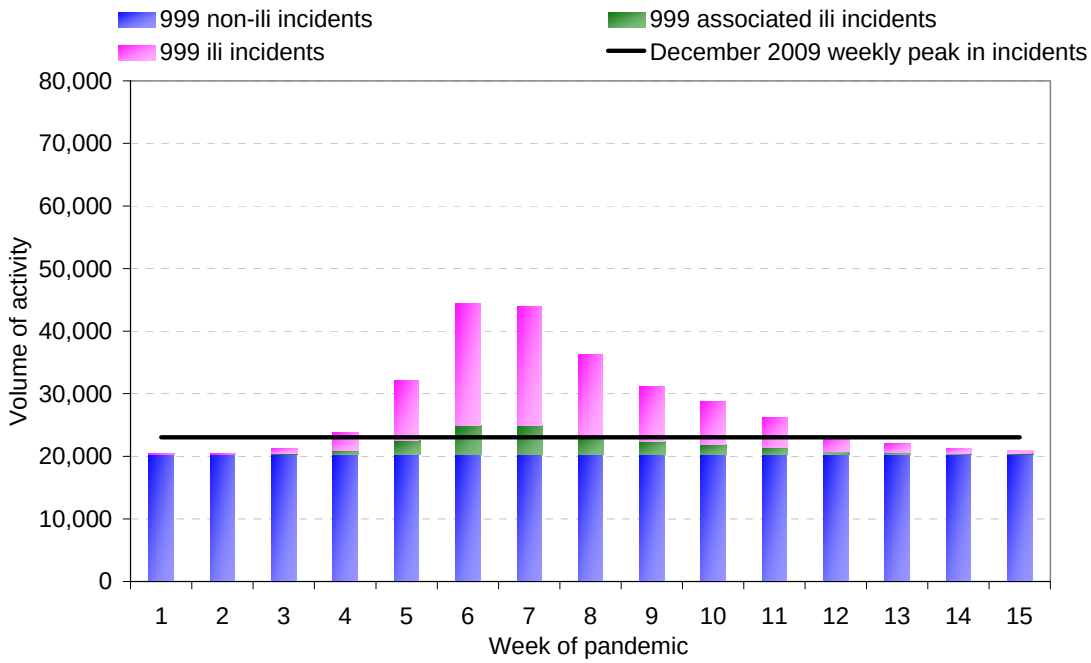



***Figure 3: emergency ambulance conveyances to emergency departments***

5.5 As a result of these predications London Ambulance Service can expect at peak, from weeks 5 to 8 of the pandemic, to be managing in the region of 500 emergency calls per hour and some 6,500 emergency responses (incidents). This document will describe later how we will prepare for such increases.

5.6 In planning to manage the impact of demand increases and a reduction in capacity due to staff absence, further modelling has been undertaken to understand the likely impact against national patient waiting time standards.

5.7 For Category A calls, 75% of all cases should be responded to within 8 minutes and for Category B calls, 95% within 19 minutes.

5.8 Table 4 below sets out the impact in percentage terms of demand increases coupled with a reduction in staff availability and its impact on performance standards (patient waiting times) on Category A (immediately life threatened patients). Table 5 describes the impact on the Category B 19 minute standard.

| Resource decrease | Demand Increase | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 0.0% | 2.5% | 5.0% | 7.5% | 10.0% | 15.0% | 50.0% | 100.0% |
| 0% | 75% | 73.8% | 72.7% | 72.1% | 71.0% | 68.7% | 35.3% | 0.0% |
| 5% | 72.0% | 71.0% | 69.9% | 68.7% | 67.2% | 64.3% | 28.1% | 0.0% |
| 11% | 68.0% | 66.5% | 64.6% | 63.3% | 61.2% | 57.3% | 14.8% | 0.0% |
| 16% | 63.5% | 61.4% | 59.3% | 56.5% | 45.7% | 36.3% | 14.6% | 0.0% |
| 21% | 56.3% | 46.5% | 35.5% | 33.2% | 32.2% | 29.0% | 14.4% | 0.0% |

***Table 4*: A8 Performance**

| Resource decrease | Demand Increase | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 0.0% | 2.5% | 5.0% | 7.5% | 10.0% | 15.0% | 50.0% | 100.0% |
| 0% | 95% | 94.3% | 94.2% | 93.7% | 93.4% | 92.4% | 52.6% | 0.0% |
| 5% | 93.5% | 93.1% | 93.1% | 92.1% | 91.6% | 90.2% | 39.7% | 0.0% |
| 11% | 92.0% | 91.3% | 90.6% | 89.9% | 88.6% | 86.8% | 13.6% | 0.0% |
| 16% | 90.0% | 89.0% | 87.5% | 85.9% | 82.6% | 53.8% | 13.6% | 0.0% |
| 21% | 84.1% | 70.3% | 51.1% | 43.2% | 42.7% | 40.1% | 13.3% | 0.0% |

***Table 5*: B19 Performance**

5.9 It must be noted that ambulance services are organisations with limited available resource to significantly increase capacity over a sustained period of time available at short notice. The majority of their assets are deployed to frontline activity as part of core activities, as a result ambulance services have very limited capacity to cope with exceptional rises in demand or decreases in capacity.

5.10 Along with the impact on patient waiting times, the likely effect on 999 call answering within 5 seconds has also been modelled. Again, reductions in staff availability and incoming demand increases have been taken into account in coming to these assumptions. Table 6 below sets out the predicted call answering performance within the Emergency Operations Centre.

| Staff Reduction | Demand Increase | | | | | |
|---|---|---|---|---|---|---|
| | | +10% | +20% | +30% | +40% | +50% |
| | 99.5 | 98.4 | 96.1 | 91.7 | 85.0 | 75.1 |
| -5% | 98.1 | 95.3 | 90.0 | 82.1 | 71.3 | 59.1 |
| -10% | 96.6 | 92.3 | 85.1 | 74.9 | 63.1 | 50.2 |
| -15% | 94.2 | 87.9 | 78.6 | 66.7 | 54.1 | 41.5 |
| -20% | 90.6 | 82.1 | 70.6 | 57.9 | 45.2 | 33.6 |

***Table 6*: % calls answered <5 secs**

| Staff Reduction | Demand Increase | | | | | |
|---|---|---|---|---|---|---|
| | | +10% | +20% | +30% | +40% | +50% |
| | 0.0 | 0.1 | 0.4 | 1.2 | 2.9 | 6.3 |
| -5% | 0.2 | 0.6 | 1.6 | 4.0 | 8.1 | 15.3 |
| -10% | 0.4 | 1.1 | 3.0 | 6.7 | 12.6 | 22.1 |
| -15% | 0.8 | 2.2 | 5.3 | 10.6 | 18.8 | 30.6 |
| -20% | 1.5 | 4.0 | 8.7 | 16.3 | 26.7 | 40.7 |

***Table 7*: Unanswered calls/hour (>1min wait)**

5.11 Table 7 above sets out the likely number of 999 emergency calls waiting in excess of 1 minute to be answered as a result in demand increases and a reduction in capacity.

5.12 Adverse weather is likely during the winter period and this coupled with the possible impact of pandemic flu will add further pressure to emergency ambulance services. Whilst snow falls of the magnitude seen in February 2009 are less likely (predicted to be a one in two decade event), snow fall is possible and there is a strong likelihood of cold temperatures.

5.13 Under normal working conditions it is widely accepted that call connect performance is exceptionally vulnerable to slight changes in demand and capacity and in line with the predicted impact of unprecedented increases in demand couple with the potential for dramatic reductions in staff availability we should expect to see significant adverse shifts in output performance to be seen.

5.14 All data quoted in these assumptions are modelled either by Department of Health analysts or produce by an independent consultancy.

## 6. Capacity and Resilience Framework (Resource Escalation Action Plan – REAP)

6.1 For the purposes of planning 6 levels of escalation will be utilised, they have been developed and agreed by the National Director of Operations Group. These levels will be used to determine what actions are necessary to protect the Trust's core services and supply the best possible level of service with the resources available.

6.2 REAP will be reported nationally as well as utilised within Trusts to guide escalation planning. It is therefore important that the levels are assessed and reported in a consistent way across all Trusts. The levels defined within this framework have been validated by ORH to ensure the key indicators are realistic. The mitigating actions are for consideration by each Trust and not prescriptive nationally.

6.3 REAP will be used as part of a forward looking planning process that forecasts performance and service delivery over the next week by assessing the likely impact of the key influencing factors. London Ambulance Service will determine the appropriate REAP level for the coming week on the basis of this analysis and forecast.

6.4 There are a wide variety of factors that can affect performance – demand, absence, external factors (weather, supply chain disruption, security threat, hospital issues etc) and internal factors (fleet issues, infrastructure problems etc).

6.5 Table 7 below sets out the 6 levels within the nationally agreed REAP that London Ambulance Service will utilise when announcing and communicating pressure levels within the Trust.

6.6 Set out in table 8 below are the triggers associated with each level of REAP. The decision to amend the REAP level in London Ambulance Service will be taken as follows:

| | |
|---|---|
| REAP 1 "normal service" | |
| REAP 2 "concern" | Deputy Director of Operations |
| REAP 3 "pressure" | Deputy Director of Operations |
| REAP 4 "severe pressure" | Deputy Director of Operations |
| REAP 5 "critical" | Director of Operations/Deputy CEO |
| REAP 6 "potential service failure" | Senior Management Group |

6.7 Each REAP level has with it a set of associated actions that will be enacted when the level is adjusted. These actions vary in seriousness and are designed to ensure that essential activities are protected and maintained as pressure builds with reducing capacity and increasing demand.

| | |
|---|---|
| REAP Level 6 | Potential Service Failure |
| REAP Level 5 | Critical |
| REAP Level 4 | Severe Pressure |
| REAP Level 3 | Pressure |
| REAP Level 2 | Concern |
| REAP Level 1 | Normal service |

*Table 7*

| *REAP Level* | *Performance* | *Factors Affecting Performance* | | | | |
|---|---|---|---|---|---|---|
| | | *Demand* | *Abstractions* | *Control Room Issues* | *External Influences* | *NHS Internal Influences* |
| 6 | Cat A > **15%** below target<br>CAT B / C < **65%** | EMS Activations > 30% above norm | Abstractions within EMS have increased by 15% over normal seasonal levels. | Abstractions within Control have increased by >20% over normal seasonal levels.<br>Call abandoned rate > 40%<br>50% calls answered within 5 seconds | Supply chain difficulties mean trust supplies are at a critical level<br>UK Alert level is | Hospital delays are being experienced at multiple sites for a sustained period<br>Major critical infrastructure issues have been experienced for a period of 24hours and are expected to continue for an unspecified time. |
| 5 | Cat A 10 – 15% below target<br>CAT B / C < 70% | EMS Activations 25% -30% above norm | Abstractions within EMS have increased by 15% over normal seasonal levels. | Abstractions within Control have increased by 15% over normal seasonal levels.<br>Call abandoned rate > 30%<br>60% calls answered within 5 seconds | Supply chain difficulties mean trust supplies are at a critical level<br>UK Alert level is | Hospital delays are being experienced at multiple sites for a sustained period<br>Major critical infrastructure issues have been experienced for a period of 24hours and are expected to continue for an unspecified time. |
| 4 | Cat A 5 – 10% below target<br>CAT B / C < 80% | EMS Activations 20% - 25% above norm | Abstractions within EMS have increased by 10 - 15% over normal seasonal levels. | Abstractions within Control have increased by 15% over normal seasonal levels.<br>Call abandoned rate < 20%<br>70% calls answered within 5 seconds | Supply chain difficulties are not manageable<br>UK Alert is | Hospital delays are being experienced at multiple sites no evidence of reduction<br>Major critical infrastructure issues have been experienced for a period of up to 24hours and are expected to continue for a specified time of no more than 24 hours. |
| 3 | Cat A 3 – 5% below target<br>CAT B / C < 85% | EMS Activations 15 - 20% above norm | Abstractions within EMS have increased by 5 - 10% over normal seasonal levels. | Abstractions within Control have increased by 15% over normal seasonal levels.<br>Call abandoned rate >15%<br>80% calls answered within 5 seconds | Supply chain difficulties are manageable<br>Severe events are having a wide spread impact in a region | Hospital delays are being experienced at multiple sites.<br>Critical infrastructure issues have been experienced for a period of 12hours and are expected to continue for a specified time of no more than 6 hours. |
| 2 | Cat A <3% below target<br>CAT B / C < 90% | EMS Activations 10 – 15% above norm | Abstractions within EMS have increased by 10 - 15% over normal seasonal levels. | Abstractions within Control have increased by 15% over normal seasonal levels<br>Call abandoned rate 10%<br>90% calls answered within 5 seconds | Supply chain difficulties are short lived.<br>Severe events are having a limited local impact on activity. | Hospital delays are being experienced at a single site.<br>Critical infrastructure issues have been experienced for a period of 6 hours and are not expected to reoccur. |
| 1 | All National performance indicators achieved | EMS Activations < 10% above norm | Abstractions within EMS are within normal seasonal levels. | Abstractions within Control are within normal seasonal levels.<br>Call abandoned rate < 5%<br>95% calls answered within 5 seconds | No reported supply chain difficulties<br>No severe events are a threat to activity | No hospital delays over 20 minutes<br>No critical infrastructure issues |

***Table 8***

# REAP LEVEL 1 – NORMAL SERVICE

| REAP LEVEL 1 – NORMAL SERVICE | ACTION | DECISION | RESPONSIBLE | IMPACT | REVIEW | SUPPORT DEPTS. | FUNDING |
|---|---|---|---|---|---|---|---|
| | Ensure staff absent are contacted regularly and on return | ROUTINE | AOM | HIGH PREVENTATIVE ACTIONS TO SUSTAIN PERFORMANCE AND PATIENT CARE | ROUTINE THROUGH WEEKLY TEAM BRIEFINGS AND MONTHLY BUSINESS MEETINGS | ROUTINE | ROUTINE NO ADDITIONAL FUNDING REQUIRED |
| | Monitor and manage sickness | | AOM | | | | |
| | Compliance with AAC and TAC policy | | AOM | | | | |
| | Actively engage local Union Representatives | | AOM | | | | |
| | Monitor and manage leave with RC | | AOM | | | | |
| | Monitor and manage mobilisation times | | AOM | | | | |
| | Monitor and manage job cycle times | | AOM | | | | |
| | Monitor and manage hours produced | | AOM | | | | |
| | Ensure provision of management cover at vulnerable timings (morning/evening changeover) | | AOM | | | | |
| | Ensure routine mobile management presence at hospitals | | AOM | | | | |
| | Manage rest breaks within guidelines | | AOM | | | | |
| | Monitor and manage all abstractions | | AOM/RC MGR | | | | |
| | Monitor and manage predicted staffing | | AOM/RC MGR | | | | |
| | Ensure maximum cover of FRUs | | AOM/RC MGR | | | | |
| | Ensure proportionate cover of AEU/FRU | | AOM/RC MGR | | | | |
| | Monitor and manage activation times | | EOC | | | | |
| | Ensure FRU / Ambulance balance is to plan | | RC'S | | | | |
| | Ensure all staffing is on the table | | RC'S | | | | |

**NB: This list is not exhaustive and demonstrates routine Trust commitments**

**Decision: Operations Directorate**

## REAP LEVEL 2 - Concern

| | ACTION | DECISION | RESPONSIBLE | IMPACT | REVIEW | SUPPORT DEPTS. | FUNDING |
|---|---|---|---|---|---|---|---|
| | ALL LEVEL 1 ACTIONS PLUS: | | | | | | |
| REAP LEVEL 2 – CONCERN | Critically review abstractions and recall where appropriate. | ADO | AOM | Low | Weekly | All Depts | No |
| | Review Control Services staffing | ADO CS | PIM CS | Med | Daily | | No |
| | Look at predicted single staff and pair up in advance. Focus resources on areas of greatest need. | ADO | AOM / RC MGR | Low | Daily | | No |
| | Daily monitoring to ensure that all rostered Team Leaders are pre-planned for shifts. | ADO | AOM / RC MGR | Med | Daily | | No |
| | Grant no more short notice leave (under 48 hours). | ADO | AOM / RC MGR | Low | Daily | | No |
| | Review all non critical meetings | ADO | AOM | | | Resource Centre | No |
| | Review predicted FRU cover and fill all gaps. Use singles off complex as necessary. | ADO | AOM / RC MGR | High | Daily | | No |
| | Increase local monitoring at Area level to ensure efficiency | ADO | PIM | Med | Weekly / Daily | | No |
| | Contact St John, Red Cross and PTS for additional vehicles. | DEP DIR OPS | CS PIM | Med | Daily | Head of PTS | Additional OT |
| | Increase focus on maximising utilisation of UCS resources | ADO CS | CS PIM | Med | Weekly | | No |
| | Review CTA staffing. | ADO CS | RC MGR CS | Med | Daily | | Additional OT |
| | Resource Centres to text overtime opportunities to staff and bank staff robustly | ADO | RC MGR'S | Med | Daily | | No |

**Decision: Operations Directorate**

## REAP LEVEL 3 – Pressure

| REAP LEVEL 3 – PRESSURE | ACTION | DECISION | RESPONSIBLE | IMPACT | REVIEW | SUPPORT DEPTS. | FUNDING |
|---|---|---|---|---|---|---|---|
| | ALL LEVEL 1 AND 2 ACTIONS PLUS: | | | | | | |
| | Establish a Trust team to manage recovery 24/7 | DIR OPS | DEP DIR OPS | High | Daily | IM&T | Yes |
| | HR Managers to manage abstraction | DIR OPS | DEP DIR HR | Med | Daily | | |
| | Team Leaders must only provide cover for vehicles. | DEP DIR OPS | ADO / RC MGR | High | Weekly | | No |
| | Review non essential abstractions. | DIR OPS | ADO | Low | Weekly | | Additional overtime |
| | CTA ring backs extended to 60m and consider additional Cat B calls for CTA. | MED DIR | ADO CS | Med | Weekly | | |
| | Offer overtime to crews who had no rest break | DEP DIR OPS | ADO CS | Med | Weekly | | Yes |
| | Review calls to NHSD and increase volume | MED DIR | ADO CS | Med | Weekly | Medical Directorate | |
| | All officers in uniform | DEP DIR OPS | ADO | Low | Weekly | | |
| | Maximise the use of PTS resources to support A&E operations. | DEP DIR OPS | HEAD OF PTS | Med | Weekly | | Additional overtime |
| | Consider treatment centres at weekends in town centres. | DEP DIR OPS | ADOS | Med | Weekly | | |
| | Consider a low level media campaign | DEP DIR OPS | HEAD OF COMMS | High | Weekly | | |
| | Review ambulance | DEP DIR OPS | HEAD OF OPS | High | Weekly | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | equipment store and order in extras as required | | SUPPORT | | | | |
| | Extended hours of Fleet Support Services:16 hours x 7 days | DIR OPS | HEAD OF OPS SUPPORT | Low | Weekly | | Yes |
| | Ensure all blue light lease cars have equipment to respond | DEP DIR OPS | HEAD OF OPS SUPPORT | Low | Weekly | | |
| | Station Management Teams to 'cold call' staff to encourage extra overtime. | ADO | AOM | Med | Weekly | | No |
| | Extended use of VAS. | ADO CS | PIM CS | Med | Weekly | VAS | Yes |
| | Staff additional FRUs against demand. | DEP DIR OPS | RC MGR | Med | Weekly | | Yes |
| | DSOs visit busy hospitals regularly. | ADO | AOM | Med | Weekly | VAS | No |
| | Cancel non-essential ECP study-day, for operational cover and return to operation duties | ADO | AOM | Med | Weekly | | No |
| | Cancel non essential Trust meetings. | ADO | SMG | Low | Weekly | | No |
| | Review planned stadia cover and minimise. | DEP DIR OPS | SEPM | Low | Weekly | EPU | No |
| | Stringent monitoring of VOR and actions to resolve. | HEAD OF OPS SUPPORT | FLEET MGR / ADO | Med | Daily | | No |
| | Review non essential training and consider re-scheduling. | ADO | HEAD OF DED | Med | Weekly | | |

Decision: Operations Directorate

# REAP LEVEL 4 – Severe Pressure

REAP LEVEL 4 – SEVERE PRESSURE

| ACTION | DECISION | RESPONSIBLE | IMPACT | REVIEW | SUPPORT DEPT | FUNDING |
|---|---|---|---|---|---|---|
| ALL LEVEL 1 – 3 ACTIONS PLUS: | | | | | | |
| Chief Officer to issue bulletin to staff outlining the position | CEO | CEO | High | N/A | Communications | No |
| Place ALOs at busy hospitals to improve turn-around. Consider non-Ops managers for this role. | DIR OPS | SMG | Med | Weekly | All Depts | Additional overtime |
| All clinically trained staff to return to covering vehicles by default, except CTA | DIR OPS | SMG | Med | Weekly | All Depts | |
| All non operational EOC trained staff return to EOC/UOC | DIR OPS | SMG | Med | Weekly | All Depts | No |
| Taxi account established for the movement of singles | DEP DIR OPS | DIR FINANCE | Low | Weekly | | Yes |
| Suspend rest breaks | DIR OPS | DIR HR | High | Weekly | | |
| Use single A&E crews to work with PTS | DEP DIR OPS | ADO / RC MGR | High | Daily | Pts | No |
| Recall all seconded staff. | DEP DIR OPS | AOM | Low | Weekly | All Depts | No |
| Suspend divert policy | DIR OPS | MED DIR / ADO | Med | Daily | | No |
| Implement the Extreme Over-Capacity Plan | DEP DIR OPS | ADO CS | High | Hourly | | No |
| Cancel all training for existing staff. | DEP DIR OPS | HEAD OF DED | High | Weekly | | No |
| DED to provide support by freeing up all clinical staff and vehicle resources. | DEP DIR OPS | HEAD OF DED | High | Weekly | | No |
| Open four work shops 24/7 | DIR OPS | HEAD OF OPS SUPPORT | Med | Weekly | Finance | Yes |
| Provide snack packs for all operational / CS staff | HEAD OPS SUPPORT | LOGISTICS MGR | Med | Weekly | Finance | Yes |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Hold supply of uniform in London | HEAD OPS SUPPORT | LOGISTICS MGR | Low | Weekly | | |
| | All DSO's available for calls 24/7 | ADO | AOM | Med | Weekly | | |
| | Review planned leave and negotiate rescheduling with staff. | DEP DIR OPS | AOM | Med | Weekly | | No |
| | Lease cars marked ready to respond | ADO | AOM | Low | Weekly | | |
| | Liaison with PCTs to explore options for additional support. | GOLD | ADO/AOM | Low | Weekly | | Yes |
| | Consider deploying VAS control staff to EOC | DEP DIR OPS | ADO CS | Med | Weekly | Resource Centre | Yes |
| | Cancel all non REAP related meetings. | DIR OPS | ALL | Med | Weekly | | No |
| | All non-essential vehicle maintenance / repair to be rescheduled. Consider out-sourcing additional servicing. | HEAD OF OP SP | FLEET | Med | Weekly | Fleet | No |
| | Make Ready to provide drivers outside of normal hours to move vehicles as required | HEAD OF OP SP | VRC | Med | Weekly | Operational support | Yes |
| | Messages to media about pressures and using the Service wisely | HEAD OF COMMS | COMMS | High | N/A | | No |
| | Inform SHA | CEO | CEO | Low | n.a | | No |
| | Introduce staff bonus scheme | DIR OPS | DIR FINANCE | Med | Weekly | Finance | Yes |
| | Only undertake emergency hospital transfers. | DIR OPS | ADO CS | Med | Weekly | | |
| | Stop all non contractual PTS work and redeploy to Cat C work. | DIR OPS | HEAD OF PTS | Med | Weekly | Medical Directorate | |
| | Participate in a daily national conference call. | DIR OPS | ON CALL GOLD | Med | Weekly | | |
| | UCS to reschedule / delay non urgent work & re-respond to amber calls. | DIR OPS / MED DIR | ADO CS | Med | Daily | | No |
| | Use private ambulances to support A&E, Cat C and B only | DEP DIR OPS | ADO CS | Med | Weekly | Procurement | Yes |

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|---|---|---|---|---|---|---|---|
| | DED to provide Trainers for operational shifts. | DIR OPS | HEAD OF DED | High | Weekly | | No |
| | Cancel all non essential training | DIR OPS | HEAD OF DED | Med | Weekly | | |
| | Extending RC cover of operations 24/7. | DEP DIR OPS | RC MGR | Low | Weekly | | Additional overtime |

**Decision: Executive Directorate**

# REAP LEVEL 5 - CRITICAL

REAP LEVEL 5 – CRITICAL

| ACTION | DECISION | RESPONSIBLE | IMPACT | REVIEW | SUPPORT DEPT | FUNDED |
|---|---|---|---|---|---|---|
| ALL LEVEL 1 – 4 ACTIONS PLUS: | | | | | | |
| Declare internal Major Incident. Advise SHA & Trust Board | CEO | DIR OPS | Med | Daily | All Depts. | Yes |
| Increase use of No Send policy | MED DIR | ADO | High | Daily | | No |
| Request national mutual aid | DIR OPS | ADO | Med | Daily | | Yes |
| Cancel all Cat C work and mental health transfers. CTA staff to triage Cat B calls before responding | DIR OPS/ MED DIR | ADO CS | High | Daily | | No |
| Cancel all PTS and non essential work and redeploy resources to support A&E ops. | DIR OPS/ MED DIR | HEAD PTS | High | Daily | | Yes |
| Cancel all event and stadia cover | DIR OPS | DEP DIR OPS | Low | Daily | EPU | Yes |
| High profile media campaign to discourage inappropriate use | DEP CE | DEP DIR OPS | High | Daily | Comms. Dept | Yes |
| Paramedics/ECPs/EMT4 to be authorised to refuse conveyance after assessment | DIR OPS/ MED DIR | MED DIR | High | Daily | DED | No |
| Use all trainees to support operations | DIR OPS/ MED DIR | HEAD OF DED | Low | Daily | DED | No |
| Open workshops at night to increase daytime fleet | DIR OPS | HEAD OF FLEET | Med | Weekly | Fleet | Yes |
| Allow reduced PRF detail completion | DIR OPS | AOMS | Med | Weekly | DED | No |
| Carry cash float to allow quick solutions | DIR OPS | DIR FINANCE | Med | Weekly | Finance | Yes |
| Ask staff to consider cancelling or buy back annual leave | DIR OPS | SMG | Med | Weekly | | |
| Book hotel rooms for essential staff | DIR OPS | HEAD OF OPS SUPPORT | Low | Weekly | | |
| Establish national co-ordination centre at LAS HQ | DEP CEO | DIR OPS | High | Daily | HR | Yes |
| Review attendance of nursing homes without | MED DIR | ADO CS | Med | Daily | | No |

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|---|---|---|---|---|---|---|---|
| | prior GP approval | | | | | | |
| | GP Admissions to be extended for 4 hours for all patients | MED DIR | ADO CS | High | Daily | | No |
| | Consider flu / incident management desk in ICR monitoring Card 36 | DIR OPS | ADO CS | High | Daily | | No |
| | Consider re-employing retired staff where possible | DIR OPS | DEP DIR HR | High | Daily | | Yes |
| | Introduce an abridged call taking / dispatch course | DIR OPS | HEAD OF DDA | Med | N/A | All Depts | Yes |

Decision: Executive Directorate

# REAP LEVEL 6 - Potential Service Failure

| | ACTION | DECISION | RESPONSIBLE | IMPACT | REVIEW | SUPPORT DEPT | FUNDED |
|---|---|---|---|---|---|---|---|
| REAP LEVEL 6 – POTENTIAL SERVICE FAILURE | ALL LEVEL 1 – 5 ACTIONS PLUS: | | | | | | |
| | All clinical qualified staff moved to frontline duties | DIR OPS | DEP DIR OPS | High | Daily | All Depts. | Yes |
| | Utilise private agency staff in the control room | DIR OPS | ADO CS | High | Daily | HR | Yes |
| | Deploy non control room staff trained in a short call taking or dispatch course | DIR OPS | ADO CS | High | Daily | HR | Yes |
| | Request GP assistance in control rooms | DIR OPS | ADO CS | High | Daily | Med Directorate | Yes |
| | Cat A calls to be prioritised by clinical support desk | DIR OPS | ADO CS | High | Daily | Med Directorate | Yes |
| | Negotiate to cancel annual leave | DIR OPS | DIR HR | High | Daily | HR | Yes |
| | Review HART / HEMS deployment | DIR OPS | DEP DIR OPS | High | Daily | | Yes |
| | Consider use of non ambulance medical responders | DIR OPS | MED DIR | High | Daily | Med Directorate | Yes |
| | Stop all PTS work and redeploy crews to assist EOC | DIR OPS | HEAD OF PTS | High | Daily | CS | Yes |
| | Release sufficient funding to fulfil REAP 6 | DEP CEO | DIR FINANCE | High | Daily | | Yes |
| | Consider Military Aid to the Civil Power | DEP CEO | HEAD OF EP | High | Daily | CS | No |
| | All Trust staff to support control and operations as required. | DEP CEO | HEAD OF HR | High | Daily | | |
| | Use private and VAS to cover for Cat A calls | DIR OPS | MED DIR | High | Daily | CS | Yes |
| | Increase use of clinical triage systems to appropriately divert patients to other providers | DIR OPS | MED DIR | High | Daily | | |
| | Significantly increase use of NHSD to deal with high category calls | DIR OPS | MED DIR | High | Daily | | |
| | Progressively restricting responses to those most seriously ill using a three stage approach | DIR OPS | MED DIR | High | Daily | | |

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|---|---|---|---|---|---|---|---|
| | where initially no response is provided to Cat C patients and then to Cat B patients and ultimately some Cat A patients | | | | | | |
| | Increase the numbers of patients who are advised to make their own way to hospital following an initial response and assessment. | DIR OPS | MED DIR | High | Daily | | |

6.8 Associated with each level of REAP are a series of actions that will be considered and where necessary enacted by the Trust with the primary aim of increasing capacity and where possible reducing demand.

6.9 Each REAP level is triggered by a set of nationally agreed parameters and monitored daily to ensure that the Trust is operating at the correct REAP level.

6.10 At REAP levels 5 and 6 we will progressively restrict responses to those who are more seriously ill. This will mean that some patients who during routine operation would receive an ambulance response will not do so.

6.11 When a change occurs to the REAP level having been so authorised by the appropriate Director, this will be supported by a bulletin to all staff in the Trust setting out the rationale for the change and sign posting all staff to the actions that now need to be enacted at a local level. In addition, the Trust's intranet home page (the Pulse) will also note the change in REAP levels.

6.12 Further guidance and clarification on the actions to be taken can be found in the LAS Capacity Plan that incorporates the Resourcing Escalatory Action Plan (REAP).

## 7. Contingency Planning and Resilience Building

7.1 It is necessary to consider contingencies for a wide range of the Trusts activities to ensure, as far as reasonably practical, the uninterrupted provision of service during the second and any subsequent waves of pandemic flu together with potential increases in demand for emergency ambulance services as a result of adverse weather during the winter.

7.2 The business areas that are subject to separate contingency planning are:

- Control Services
- Operations (areas)
- Resource centres
- Command and Control
- General staff availability
- IM&T
- Procurement and logistics

7.3 In addition to specific plans for the most important and vulnerable business areas, routine business continuity arrangements have been refreshed and tested as recently as July 2009.

7.4 Pro-active contingency planning for control services is broken into a number of key areas, these are:

- Call taking
- Dispatch
- Incident response
- Clinical Telephone Advice (CTA)
- Clinical Support Desk (CSD)
- Mutual aid
- Capacity management notifications and actions

**Call Taking**

7.5 Control services is comprised of two business areas; emergency and urgent operations. The establishment across the two business areas totals 406 whole time equivalents (WTE) of which roughly 50% are engaged in emergency call taking activity.

7.6 Training for direct entrants to the Trust to be effective as an emergency call taker comprises numerous modules and totals four weeks. A course of two weeks is available for current employees of the Trust who are willing to work within Control Services during times of peak demand. Some 30 such staff have volunteered to work

within Control Services during peak periods of demand within the Pandemic and will be trained during October to do so.

7.7 An additional 52 staff are to be recruited and trained in full time posts within Control Services between September and December 2009. These staff will add yet further resilience to the call taking area.

7.8 If further call taking capacity is required agency staff could be deployed to take emergency calls only (no other control room functions) following the successful completion of the two week course. We have existing arrangements with a number of agencies that we would seek such staff from. These staff would then be deployed alongside existing call taking staff, and administrative staff trained to take emergency calls during periods of extreme demand.

7.9 Call taking capacity within our main control room is 35 and at our fall back facility, 24. During periods of exceptional demand we could utilise the total call taking positions available, staffing these as set out above and thus roughly doubling our normal call handling capacity.

7.10 These arrangements will be co-ordinated by the Assistant Director of Operations, Control Services.

**Dispatch**

7.11 Staff trained to work in dispatch functions are longer in service and have been subject of additional training. Whilst some staff currently deployed in call taking could be redeployed and backfilled with other staff, the majority of additional staffing for these areas will come from Control Services staff who have re-graded to Student Paramedic in recent months and from other non-essential areas of the business unit such as Quality Assurance.

7.12 Dispatch staff will remain at our main control room and we will not split the function between our main and fall back control centres. Where possible we will continue to operate the split sector regime currently in place however should staff shortages necessitate the closures of split sectors to ensure an appropriate mix of staff skills these will be enacted on a priority basis. The split sectors will be combined in the following order:

- East Central
- North West
- South West
- West
- North East

- South East

7.13 These arrangements will be co-ordinated by the Performance Improvement Manager for Control Services.

**Incident Response (Control Services)**

7.14 In the event of an incident that requires the facilitation of the incident control room (ICR) staff will be deployed from the main control room as necessary to undertake these functions. It will be the role of the EOC incident commander in conjunction with Gold Medic to make an assessment within the first hour of the incident as to its likely duration. Should this assessment indicate the incident is likely to exceed three hours in duration, off duty staff who have indicated a willingness to be available at short notice for overtime will be contacted by the Control Services resource centre and asked to attend for duty.

7.15 Should specialist staff be required to work in police control rooms to manage such incidents, those staff that are suitably trained and who are now not primarily deployed within Control Services should be utilised to fulfil such functions.

7.16 These arrangements will be co-ordinated by the Performance Improvement Manager for Control Services.

**Clinical Telephone Advice (CTA)**

7.17 It is vital that suitable capacity to manage green call demand and referrals to NHS Direct are maintained during the period covered by this framework. CTA deal with an ever increasing profile of overall demand and will be a key tactic in the management of excessive demand associated with swine flu during this period.

7.18 A new CTA hub will open in South London, operating remotely from the main control room and will increase capacity in this area. This is likely to be operational from December 2009.

7.19 Prior to this time, should additional CTA capacity be required, staff who have previously worked in CTA will be recalled from their current posts to undertaken duty within CTA.

7.20 The facility will be suitably staffed on a 24/7 basis and capacity will be increased during the peak weeks of the pandemic wave.

7.21 Suitable calls will be passed to NHS Direct for further assessment and advice in line with existing arrangements and only in a minority of cases will the call be referred back to the control room for an ambulance to be assigned.

7.22 All green calls to under 5s and over 65s will automatically receive an ambulance response and not be referred via CTA to NHS Direct for assessment.

7.23 These arrangements will be co-ordinated by the Ambulance Operations Manager for Urgent Care.

**Clinical Support Desk (CSD)**

7.24 Staffed on a 24/7 basis this service provides clinical peer review and support by telephone to frontline staff at the incident scene. The service is an essential part of our flu management plan and played a vital role during the first pandemic wave in signposting ambulance crews to appropriate pathways of care for patients with flu like symptoms.

7.25 During the winter of 2009/10 the desk will enhance its staffing arrangements and has planed to yet further enhance capacity during weeks four to eight of the pandemic wave. These arrangements will be on a 24/7 basis.

7.26 These arrangements will be co-ordinated by the Assistant Medical Director, Control Services.

**Mutual Aid**

7.27 Control room mutual aid between UK ambulance services has been tested in the live environment within the last twelve months with a number of LAS staff being deployed in another Trust.

7.28 These arrangements will be co-ordinated and facilitated through the National Co-ordination Centre to be hosted by LAS during the period covered by this framework.

7.29 Should LAS see substantial shortfalls in the number of staff required to operate emergency call taking and dispatch functions as a result of staff absence or substantial increases in demand for our services, mutual aid will be requested having exhausted options within the Trust to enhance capacity. These will be through the use of administrative and agency staff call takers and the recalling of staff who have previously worked within control services from their current posts.

7.30 These arrangements will be co-ordinated by the Director of Operations.

**Capacity Management Notifications and Actions for Incoming 999 Calls**

7.31 Recorded messages on incoming 999 lines for those callers who wait 60 seconds or more for their call to be answered will be played to inform service users of the increase in demand for our services.

7.32 They will carry self-help messages for those suffering from flu like symptoms and refer them to the National Flu Service or NHS Direct.

7.33 We will cease the automatic sending of ambulances on address only, designed during times of routine demand to activate the nearest ambulance to a call as quickly as possible, so that we are sure of the diagnosis of the call prior to assigning an ambulance resource. We will need to do this to ensure that ambulances are assigned to calls based on clinical priority only.

7.34 Under active consideration at a national level are adjustments to the BT 999 operator regime. These could be adapted to include a reference to flu issues at the point when the relevant service is requested (Police, Fire, Ambulance or Coast Guard).

7.35 This adjustment could significantly reduce the demand placed upon the London Ambulance Service as each call that was solely related to flu would be passed to the National Pandemic Flu Service prior to being connected to our 999 switch.

7.36 These arrangements will be co-ordinated by the Assistant Director of Operations, Control Services.

**Operations (areas)**

7.37 Resilience in operational areas will taken the form of:

- Enhanced resource centre opening hours
- Enhanced area delivery unit hours of operation
- Streamlined and centralised sickness reporting arrangements
- Extended overtime working and incentive arrangements
- Increased utilisation of voluntary aid societies (VAS) and private providers
- Additional complex response (ACR), utilisation of complex based training officers and operational managers with clinical skills and lease cars
- On duty senior management arrangements and strategic steering arrangements
- Mutual aid

7.38 The frontline operational establishment of the Trust is 3313. The graph below at figure 4 shows the current recruitment trajectory to this establishment. The

operational establishment grew by nearly 400 in this financial year and current recruitment activity is on track to recruit all these staff by the Spring/Summer of 2010.

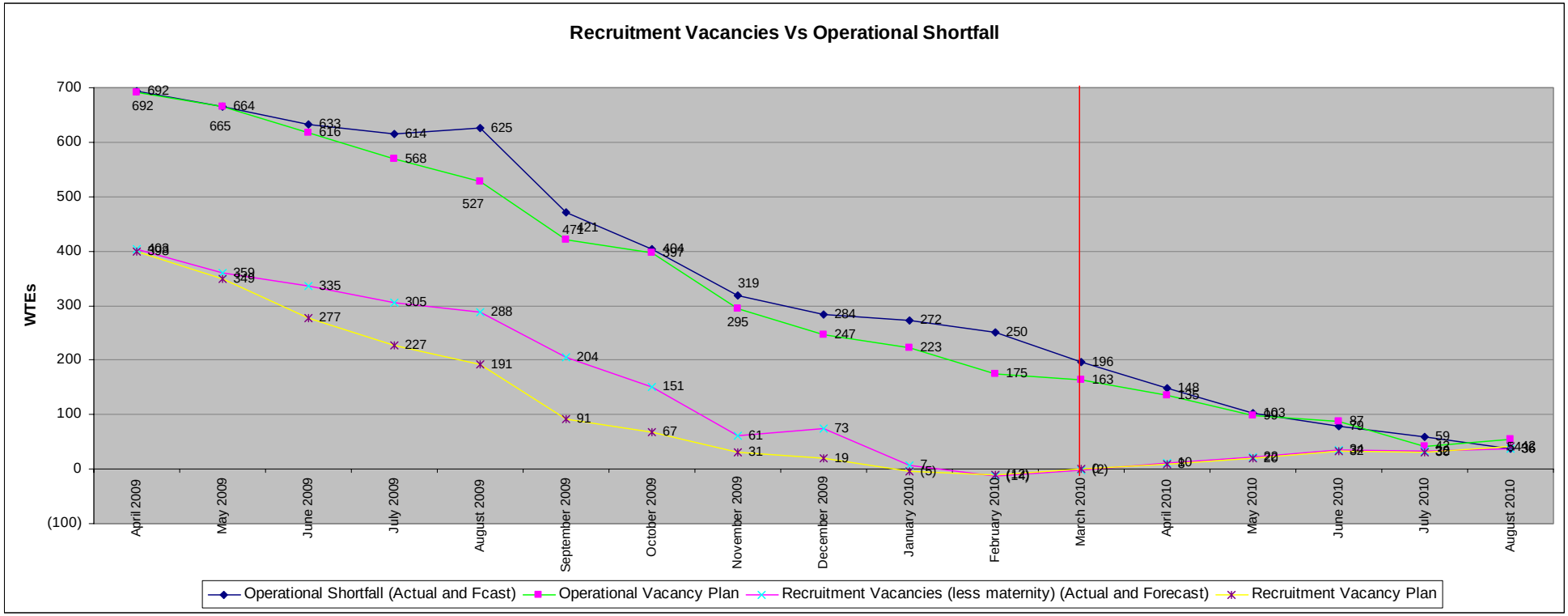
Recruitment Vacancies Vs Operational Shortfall
WTEs
700
600
500
400
300
200
100
0
(100)
April 2009
May 2009
June 2009
July 2009
August 2009
September 2009
October 2009
November 2009
December 2009
January 2010
February 2010
March 2010
April 2010
May 2010
June 2010
July 2010
August 2010
Operational Shortfall (Actual and Fcast)
Operational Vacancy Plan
Recruitment Vacancies (less maternity) (Actual and Forecast)
Recruitment Vacancy Plan

***Figure 4***

**Enhanced Resource Centre Opening Hours**

7.39 Currently the two operational resource centres servicing the three operational areas are open from 0600 until 2400 hours, 7 days a week.

7.40 During the peak weeks of the pandemic or during periods of adverse weather when demand on the Trust will be at its highest, these centres will pool staff and provide one open and functional resource centre 24/7. The burden will be shared amongst the two sites and staff.

7.41 Operational staff will be able to report their availability and single staff will be paired in real time, reducing down time and increasing availability.

7.42 Sickness will be reported to the Resource Centre in the normal way and where an immediate management intervention is necessary, this will be undertaken by the relevant area delivery unit who will also be operating on a 24/7 basis during the peak weeks of the pandemic.

7.43 These arrangements will be co-ordinated by the Senior Resourcing Manager.

**Enhanced Area Delivery Unit Hours of Operation**

7.44 Area delivery units will co-ordinate, in real time, issues affecting the production of ambulance and fast response unit hours and matters affecting vehicles off the road. They will trouble shoot these issues on an extended hours basis during the peak weeks of the pandemic or during periods of adverse weather.

7.45 Current hours of operation of 0700 until 1900 hours will be extended to 0600 until 2400 hours daily.

7.46 Additional staffing to these units, based centrally within the Central Support Unit, will be provided from the area management teams.

7.47 These arrangements will be enacted by the Assistant Director of Operations for each operational area.

**Streamlined and Centralised Sickness Reporting Arrangements**

7.48 Sickness reporting arrangements will be strengthened during the peak weeks of the pandemic and during periods of adverse weather through the resource centres and their extended hours of operation.

7.49 Operational management intervention will be provided in each case immediately should this prove necessary.

7.50 A follow up call will be made within 24 hours by a member of the HR team and suitably recorded and reported to the local management team.

7.51 Local management teams will not be required during these times to contact staff who are absent due to sickness as part of their routine contact arrangements. However, they will remain responsible for the timely enactment of the relevant stages of the managing attendance procedure.

7.52 These arrangements will be co-ordinated by the Senior Resourcing Manager.

**Extended Overtime Working and Incentive Arrangements**

7.53 Overtime working will be targeted to times of peak demand and may be incentivised at these times to ensure optimum availability.

7.54 Incentive payments will be brigaded to periods during the peak weeks of the pandemic or during periods of significant adverse weather in an attempt to produce significantly increased ambulance hours to protect as far as is reasonably possible, patient waiting times.

7.55 The framework for previous incentive schemes that have produced the most additional hours will be utilised during these periods.

7.56 Incentive payment arrangements will be co-ordinated by the Deputy Director of Operations.

**Increased Utilisation of Voluntary Aid Societies (VAS) and Private Providers**

7.57 Routine daily operations sees the deployment of private providers within the urgent care fleet to boost available resources to manage Category C workload while additional staff are recruited and trained for these vacancies.

7.58 These numbers will be boosted where possible during the peaks weeks of the pandemic and during periods of adverse weather.

7.59 Existing accreditation arrangements will be utilised to ensure that clinically safe and appropriately trained private providers are utilised.

7.60 Use of voluntary aid societies, principally St John Ambulance and the British Red Cross, will be stepped up during times of peak demand and existing arrangements for their control and deployment to calls will be utilised.

7.61 It is envisaged that private providers and VAS will have only a limited capacity to provide additional resources during this period.

7.62 These arrangements will be co-ordinated by the Ambulance Operations Manager for Urgent Care.

**Additional Complex Response (ACR), Utilisation of Complex-based Training Officers and Operational Managers with Clinical Skills and Lease Cars**

7.63 The requirement for complex management teams to provide additional complex response will be extended during the peak weeks of the pandemic or during periods of adverse weather.

7.64 These additional response cars will be targeted to calls in line with the arrangements for core fast response units and will be targeted to times of peak demand and abstraction of core resources.

7.65 Each ambulance complex and management team will be required to provide 12 hours cover each day. This will be made up of managers including Team Leaders and Training Officers. It will not involve frontline operational staff on overtime. The response will be truly additional and operate during times of extremis.

7.66 Complex based training officers will defer all routine activity in line with the prevailing REAP level and in any event at REAP 4 or above will devote all of the working week to the provision of frontline cover either by way of ambulance or fast response unit deployment or in the provision of additional complex response.

7.67 Operational managers with lease cars and who come from a clinical background within the Trust will be encouraged to make themselves available to respond to calls in their lease cars at REAP 3 or above. New guidance will be issued setting out the operating regime for this scheme during September.

7.68 At REAP 4 or above such managers at complex and area level will be required during duty periods to announce their availability to the emergency operations centre to respond to calls via the airwave tracking and dispatch arrangements.

7.69 Emergency planning advisors, officers assigned to duties within CBRN and HART business units and those officers with clinical backgrounds operating within Headquarters functions will also be required to operate as set out in 7.56 and 7.57 during the peak weeks of the pandemic wave or during periods of sustained adverse weather.

7.70 These arrangements will be co-ordinated by the Deputy Director of Operations.

**On Duty Senior Management Arrangements and Strategic Steering Arrangements**

7.71 On duty and on call arrangements during the peak weeks of the pandemic and sustained adverse weather conditions will be strengthened.

7.72 Tactical or Silver level on duty arrangements will be extended from one on duty 24/7 to two on duty 24/7 with a third back up on call 24/7.

7.73 Strategic or Gold level on duty cover will be enhanced to provide one on duty 24/7 and the on call arrangements will remain in place providing a second officer at strategic level should the need arise.

7.74 On duty Operational or Bronze level cover will robustly be maintained with a minimum of seven on duty Duty Stations Officers (DSOs) our of hours and a minimum of 21 during normal working hours.

7.75 With the exception of the Strategic level cover that will be co-ordinated by the Head of Emergency Preparedness, the arrangements for Tactical and Operational cover will be co-ordinated by the Chair of the pan London AOM group.

7.76 The Trust strategic flu group chaired by the Deputy CEO will meet daily during the peak weeks of the second pandemic wave providing direction and guidance to the Trust on issues associated with flu demand and capacity.

7.77 The Trust's operational flu group will meet twice daily by telephone conference to oversee operational issues associated with pandemic flu during the peak weeks of the wave and will be co-ordinated by the Head of Emergency Preparedness. The group will act upon intelligence gathered from across the Trust and ensure ongoing preparedness to manage flu associated activity as far as reasonable practicable.

**Mutual Aid**

7.78 Mutual aid between UK ambulance services has been tested in the live environment within the last twelve months with large numbers of operational staff being deployed from across the country to work in London over a four day period during the London Summit.

7.79 These arrangements will be co-ordinated and facilitated through the National Co-ordination Centre to be hosted by LAS during the period covered by this framework.

7.80 Should LAS see substantial shortfalls in the number of staff required to produce sufficient ambulance and fast response unit hours to sustain safe and reasonable (in the prevailing context) levels of service as a result of staff absence or substantial increases in demand for our services, mutual aid will be requested having exhausted options within the Trust to enhance capacity. Further information on the arrangements to enhance operational staffing prior to any request for mutual aid being made can be found within the Human Resources section of this framework.

7.81 These arrangements will be co-ordinated by the Director of Operations.

**Transport Hubs**

7.82 In the event of adverse weather or sustained staffing issues within public transport providers as a result of pandemic flu that restricts the operation of public transport that in turn leads to difficulty in staff being able to get to work we will host transport hubs where staff can report and access LAS transport to their place of work.

7.83 These transport hubs will be located at:

- Bromley
- New Malden
- Ilford
- Deptford
- Hanwell
- Brent
- Newham

7.84 These arrangements will be co-ordinated by the Senior Resourcing Manager.

**Accommodation**

7.85 Should public transport restriction inhibit the ability of key staff to return home and they are willing to stay locally to their place of work for a period during periods of intense demand, existing arrangements with local providers of hotel accommodation will be used to secure suitable hotel rooms.

7.86 These arrangements will be co-ordinated by the Staff Officer to the Deputy Director of Operations.

**Other Directorates Resilience Planning**

7.87 Each directorate is required to have a business continuity plan. Following a Trust wide pandemic flu specific business continuity event held in July 2009, each directorate has been required to provide assurance that their plan tackles issues likely to arise within a flu pandemic.

7.88 The plans have been subject to scrutiny from the Trusts Business Continuity lead and in some cases specific plans to manage issues associated with pandemic flu have been designed.

7.89 Business critical teams such as those within IM&T that manage call taking and dispatch functionality have developed a bespoke plan to maintain such services and support to those serviced during a pandemic if key staff are absent due to sickness.

7.90 These plans also look at methods of limiting infection in key staff groups and provide opportunities for key individuals to work from home, therefore limiting their risk of infection whilst using public transport and being in the work place and enabling them to provide their specialist support remotely.

**Bunkered Fuel and Agency Cards**

7.91 The Trust continues to maintain and grow it in house supply of Diesel fuel. By January 2010 some 100,000 litres of fuel will be held in secure locations for use if the public access fuel supplies are disrupted for any reason.

7.92 This supply would provide sufficient fuel for every Trust vehicle for 3 to 5 days. We continue to enhance the stocks of Diesel that we hold and will hold 250,000 litres by the end of 2010.

7.93 Fuel for all ambulance vehicles is procured at the point of sale with BP agency cards. These cards can be used at Total filling stations to purchase fuel if BP garages do not have sufficient fuel.

7.94 Each senior operational managers within the Trust has a purchasing card (company credit card) and should BP and Total filling stations not be able to supply us fuel for a period of time, fuel can be purchased from other suppliers forecourts by way of purchasing card.

7.95 A Number of additional fuel cards will be held centrally that permit the purchase of fuel from any forecourt. These will be used in extremis, when BP and Total are not longer able to provide fuel.

**Equipment Stockpiles (flu and non flu)**

7.96 The Trust has stockpiled three months worth of supplies that are required to maintain infection control arrangements associated with pandemic flu. In addition, three months supply of our regular use items have also been stockpiled.

7.97 The stock piles are held centrally. In the event the NHS supplies are unable to provide local deliveries of such items through the normal procurement arrangements, these stock piles can be accessed and delivered to station.

7.98 These arrangements will be co-ordinated by the Head of Operational Support.

**Hospital Delays and Diverts/Closures**

7.99 Existing arrangements for the management of requests for hospital Accident and Emergency department diverts and closures will be used during any flu pandemic and during times of additional pressure during the winter period.

7.100 These arrangements provide facilities for conference calls hosted by LAS between acute Trusts that are under pressure and their neighbours.

7.101 The arrangements were used successfully last winter and have also been deployed during periods of peak demand during the summer months.

7.102 A suite of additional capacity management tactics are available across the LAS area to respond to situations where ambulance crews are delayed in handing over patients at A&E departments due to a lack of capacity.

7.103 The divert and closure arrangements are shown at appendix Q of this framework.

7.104 The arrangements will be overseen by the Assistant Director of Operations, Urgent Care.

**Adverse Weather**

7.105 In the event of adverse weather the Trusts response will be co-ordinated by the Central Support Unit based at Headquarters. Here a Gold level officer will direct activity across the Trust to maintain services to national standards as far as is reasonably practicable.

7.106 Snow socks have been issued to each ambulance station and on call manager. In the event of snow fall on untreated roads these socks can be affixed to the vehicles wheels and provide additional traction enabling the vehicle to drive in such conditions.

7.107 Further supplies of the socks are held centrally enabling immediate replenishment.

7.108 The Emergency Preparedness Department receive weather warnings direct from the Met Office and where these indicate a likelihood of adverse weather early interventions will be triggered to mitigate the impact on the provision of core services.

7.109 These arrangements will be co-ordinated by the Head of Emergency Preparedness.

**Vaccination Programme for all Staff**

7.110 The Trust is actively encouraging all staff to take up the offer of the annual seasonal flu vaccine. There has been a number of communications to all staff groups in this regard.

7.111 A patient group directive (PGD) has been approved and this provides the opportunity for all staff to access the seasonal vaccine through a network of trained professionals (Paramedics) within the Trust.

7.112 The training has already been provided to some 100 staff and each locality has numerous staff that can deliver the vaccine at a local level.

7.113 Equipment has been procured to deliver the vaccine and each trained member of staff who will deliver the vaccine will be issued with a kit to do so.

7.114 Each main ambulance station and headquarters building will have a vaccine fridge installed during September and these will be used to house the vaccine prior to delivery at a local level.

7.115 Once the swine flu vaccine is available, this will be delivered by the same trained staff at each main station and headquarters location.

7.116 Staff are being actively encouraged to take up the offer of the swine flu vaccine. The London Ambulance Service intends to secure sufficient swine flu vaccine so that all members of staff within the Operations Directorate have the opportunity of doing so should they choose to seek the vaccine.

7.117 These arrangements will be co-ordinated by the Medical Director.

## 8. Clinical Strategy

8.1 The UK Ambulance Services and in particular the London Ambulance Service are preparing for the demand pressures that may occur in adverse weather or as a result of pandemic flu and are planning so that the provision of high quality patient care is maintained to the highest possible standards during times when demand exceeds capacity. This clinical strategy sets out how this will be achieved.

8.2 We shall employ the following clinical tactics to maintain clinical services to patients who need them most:

- A stepwise approach to the allocation of resources and the provision of responses based on clinical need
- A telephone triage system (MPDS) will continue to be used to ensure those with the most clinically needy presentation get the fastest response
- Calls that do not get an automatic response will need a Clinical triage assessment through our Clinical Telephone Advice (CTA) provisions using PSIAM
- Once it is necessary to restrict responses due to extreme capacity issues the focus will be on clinical safety that prioritises the sickest first

8.3 There is an agreed national approach to the five key areas of clinical strategy that the London Ambulance Service will adopt during the winter of 2009/10. These are:

1. Managing Excess Demand
2. Clinical Triage
3. Treatment Options
4. Maximising Skill Mix
5. Infection Control

**Managing Excess Demand**

8.4 When REAP levels are raised to level 5 and 6 it will be necessary to restrict the response of ambulance service assets to emergency calls that present with less immediate or needy clinical conditions. The aim is to provide a core clinical service for life threatening conditions.

8.5 At these levels of activity targets related to times become irrelevant as calls are likely to end up in a stack. There are several actions that can maximise resource and minimise clinical risk, and the national Ambulance Service Medical Directors group have reached consensus on a step wise approach.

- **Level 1:** Respond to Category A&B, if possible send appropriate Cat C code set to NHSD or CTA

- **Level 2 :** Respond to Category A, Triage B (except under 2 and over 70) via CTA
- **Level 3 :** Respond to Category A only
- **Level 4:** Restrict the number of Category A calls responded to utilising the red 1, 2 and 3 triage sieve

8.6 The dispatch cycle can also be minimised by terminating the call when the dispatch code has been established. Post dispatch advice may appropriately be given, but it is not necessary to continue this advice until arrival of resource. Similarly for those calls passed for telephone assessment, that a standard statement be included to advice the caller that call back may take up to an hour and only to call back if the condition deteriorates, this will minimise repeat calls.

8.7 One area for further review and discussion across health communities is the significant numbers of calls from nursing and residential homes that would often be better dealt with by primary care. As the REAP level rises and we begin to restrict our response to emergency calls as set out in this strategy, we will restrict our attendance at nursing and residential home facilities to Category A calls only.

**Clinical Triage**

8.8 The current telephone triage systems will remain in place during any pandemic or increase in demand as a result of seasonal pressures. These systems are vital in ensuring we respond to those calls that are immediately life threatening as we begin to restrict those calls that we will respond to.

**Treatment Options**

8.9 There is national agreement that there are changes to clinical practice that can reduce the job cycle, without significant increase in clinical risk or adverse impact to the patient.

8.10 If patients are capable of walking then for these patients to present themselves into the walking /minors side at the emergency department rather than being booked in by ambulance staff can decrease turn around and also tackle the myth that you are seen quicker in ED if you arrive by ambulance.

8.11 Patients assessed by a solo responder will often be stable enough to be left at the address to await transport rather than initial response waiting for back up to arrive.

8.12 Staff can be encouraged to minimise on scene time, only providing that investigation and treatment that is essential for or associated with the presenting condition(s).

8.13 A clinical record that provides the minimum data for safe care and handover is still required.

**Maximising Skill Mix**

8.14 The London Ambulance Service will maintain services as far as reasonably practicable to those patients with immediately life threatening conditions in the situation of demand far out stripping available resource.

8.15 Clinically the aim is to deliver a clinical assessment from a trained ambulance clinician which can then be followed by a non-qualified transport service once assessed (if appropriate).

8.16 The following skill mix options exist and are available to deploy as appropriate as demand continues to rise, outstripping supply:

- Concentrate trained staff in solo response vehicles to make initial assessment, backing up only with an ambulance if the call immediately warrants the deployment or following the on scene assessment, the patient must be conveyed to hospital
- Split trained crews by adding a A&E support or PTS staff member to assist and therefore increase capacity
- Use CFR/ECA as first response to provide BLS if nearest/only resource

**Infection Control**

8.17 It is essential during the pandemic phase to limit the opportunity of infection to health workers and in that regard the London Ambulance Service has taken the following infection prevention steps:

- Issued all staff FFP3 respirators
- Issued guidance on the use of PPE and routine infection control arrangements to all staff
- Locked down areas of highs risk to essential staff only (control rooms)
- Procured and placed in all public areas within our buildings alcohol hand gel
- Issued cleansing wipes for control room telephones and keyboards

**Clinical Oversight**

8.18 The arrangements within this clinical strategy will be co-ordinated by the Medical Director.

## 9. Framework Principles for the Management of Staff Attendance in the Event of a Declared Outbreak of Pandemic Flu

9.1 The following guidance has been produced in line with the both the national Human Resources (HR) guidance and the ambulance-specific HR guidance agreed and endorsed by national ambulance HR Directors in July 2009.

9.2 It out-lines key workforce considerations to be taken into account when planning and preparing for managing staff attendance, staff support and maintaining service delivery during the flu pandemic and winter period.

9.3 The guidance will also form the basis for partnership consideration of these issues through the joint pandemic Flu working group being established with the recognised trade unions.

9.4 With specific reference to the pandemic, it is anticipated that there will be four reasons why staff may not attend for work:

- They are unwell.
- They have dependents who are unwell, and have carer responsibilities.
- They have a genuine fear/phobia, independently confirmed by e.g. a GP, that travelling to and attendance at work increases their risk of exposure to pandemic flu, and that as a direct consequence they may become ill.
- They are unable to travel due to disruption to the public travel arrangements or fuel supply.

9.5 These reasons for potential absence must be seen against the following context:

- The contract of employment remains in place – this means that contractual rights and entitlements must be maintained unless a variation is agreed.
- Health and safety requirements remain in place – this means that the trust must maintain safe working practices and discharge its duty of care.

9.6 Consequently:

- Planning needs to maintain a balance between staff need and service provision/patient care.
- Service provision should be reviewed to determine what are “essential” services that must be maintained, and what are “non-essential” services in the sense that these may be *safely* postponed/deferred.
- This principle applies equally across all Directorates/Departments, not just to “patient-facing” roles, the aim being to maximise staff availability for core/essential service provision.

9.7 The aim of this framework is to promote a position whereby staff do not simply report their non-availability or non-attendance, but engage in meaningful (therefore two-way, with managers to give proper and serious consideration to any requests or proposals) discussion with their manager about alternative arrangements.

9.8 Flexibility is key to achieving this outcome, and in this regard:

- Staff will be expected to **attend** for work unless impossible, in which case…
- Staff will be expected to be **available** for work unless impossible
- Such work may include different duties, different working times or working days, or working from other locations
- Managers and employers have a responsibility to consider staff needs and suggestions.

*N.B. Disciplinary action, although not precluded, must be carefully considered and represents a last resort where a staff member has failed to attend without good reason or cause, and therefore is deemed to have refused a reasonable instruction.*

9.9 Effective prior communication with staff, managers and unions is vital. Guidance on key areas, such as the continued application of the Managing Attendance procedure, will be provided and communication and consultation will continue through the staff council, its constituent bodies, and the joint pandemic Flu group. Wherever possible, subject to the over-riding requirement to maintain service delivery in line with any agreed variations through .e.g. REAP and over-capacity plans, arrangements will be agreed locally in partnership.

9.10 Key areas for consideration and review are listed below. Contingency planning is likely to include flexible application of such HR activity and, depending upon the prevailing circumstances and pressures experienced by the service, may also whether some policies are to be suspended or superseded.

9.11 The key policies and procedures that will be under active consideration through enhanced partnership arrangements set against the prevailing circumstances are:

- Annual leave arrangements
- Sickness absence reporting and management procedures
- Review/extension of flexible working arrangements
- Time off for public duties
- Review/defer retirements
- Recruitment and training activity
- Conduct of appraisals
- Disciplinary investigations/hearings
- Grievance investigations/hearings

- Capability procedures

This list should not be taken to be exhaustive or exclusive.

9.12 Initial considerations and actions associated with each specific policy or procedure are outlined below:

**Annual Leave**

- A blanket ban is unlikely to be appropriate or practical, and will not be seen as supportive of staff working under additional pressure.
- All requests for leave will be considered on their merits and the circumstances at the time rather than a broad or blanket refusal of leave.
- Staff may, however, be asked to review any pre-booked annual leave commitments and offer their availability if needed, on a voluntary basis.
- If holidays are booked without staff obtaining prior approval, annual leave is unlikely to be granted retrospectively.
- If financially viable, subject to the WTD limit of 20 days (excluding public holidays) staff may be given the option to receive payment in lieu of some/all of their remaining annual leave. Reducing annual leave entitlements, however, is not an option.
- Where staff are unable to take their full entitlement to annual leave, consideration may be given to increasing the carry over provision, or potentially compensating staff for some/all of the untaken proportion.
- Where staff have no remaining annual leave but need additional time off to care for dependents, consideration may be given to bringing forward some of the next year's entitlement.

**Sickness Absence**

- Normal or improved sickness absence reporting and recording activities will be required to understand (real time) workforce availability and impact on service provision.
- Consideration is being given to establishing a central absence reporting point for all staff.
- In order to understand the impact of flu-related absences, and in anticipation that there will be a requirement to report all staff absences and flu-related absences to NHS L and nationally, additional efforts will be made to establish and record the reasons for **all** absences.
- Clinical advice and information is available to staff through the Clinical Support Desk in EOC.

- Requirements for self-certification and provision of medical certificates to support absence due to sickness will be in line with national (DH) guidance or any agreed variation.
- In accordance with normal attendance management arrangements, the Trust will take whatever steps deemed appropriate to be satisfied that staff absences are for genuine reasons.
- All absences will continue to be managed under the agreed and existing Managing Attendance Procedure (MAP).

**Consideration for Flexible Working Options to include**

- Review of individual/group working patterns/hours
- Ask part-time staff will be approached to increase their hours (voluntary)
- Where appropriate, staff may be allowed to work from different Trust locations
- Where appropriate, depending upon job role and feasibility, staff may be allowed to work from home.
- Other suggestions or requests from staff will be given reasonable consideration.

**Childcare/dependent Responsibilities**

Whilst consideration should be given to extreme extenuating circumstances and all flexible working options should be considered, the Trust's agreed carer policies and procedures remain in place. In this regard, the underlying principle that staff may request carer leave where other arrangements have broken down/are unavailable remains.

Other options to support staff through longer periods where they need to care for dependents which could be considered include:

- Alternative individual working patterns
- For staff with carer responsibilities live near to each other, reviewing working patterns to facilitate sharing of those responsibilities
- Flexible working arrangements, including home working (if possible/appropriate. This may depend upon the staff group in question or the specific role undertaken.)
- Extended unpaid carer/special leave provisions.
- Where unpaid leave is requested and agreed, consideration may also be given to deferring salary deductions/agreeing an extended schedule of repayment.

**Time off for public duties (e.g. jury service etc)**

- Where staff are called up for jury service, the Trust will in all cases seek deferral based upon the needs of the service.
- Requests for special leave with pay (i.e. in work time) to fulfil public duties such as school governor or magistrate responsibilities are unlikely to be approved.

However, since these duties are confined to a single day/part-day, consideration may be given to e.g. shift changes to enable the responsibility to be discharged.

- Requests for special leave for TA and Reserve duties are unlikely to be agreed within the period of the pandemic/extreme winter pressures. Staff will be asked to defer such requests.

Any other special leave for public duties will be considered based upon the prevailing situation facing the trust, but paid time is unlikely to be agreed during the pandemic period itself.

**Appraisals**

- Conducting appraisals is likely to be impractical
- Scheduled appraisals will be suspended until after the pandemic
- The appraisal system will then be re-instated as part of the recovery process of returning to "business as usual".
- A practical, common-sense approach should be adopted. Depending upon the duration of a pandemic, "catch-up" activity may not be deemed appropriate.

**Disciplinary/Grievance/Capability Issues**

- It will be necessary to review and consider, on a case by case basis, whether to proceed with disciplinary/grievance/capability investigations and processes.
- Such review will be co-ordinated by the HR Team, and will involve other senior management as appropriate.
- Those affected will be kept informed.
- On a case by case basis, the Trust will review current suspensions and consider whether any affected staff may return to work in their contracted or alternative duties.
- If suspension of disciplinary/grievance processes is agreed managers should write to the individual(s) concerned.
- As best practice, consideration will be given to establishing a central group to review all cases and decide whether to proceed with disciplinary investigations. This will promote consistency in decision making.

**Redeployment**

It is a reasonable expectation that staff will/may be required to work flexibly, possibly working at different sites or in different roles, but always within their skill set, and within the boundaries of personal fitness, safety and competence.

- To support this principle, the Trust has undertaken a formal skills audit
- Subject to suitability, any training need and the requirements of any professional or statutory bodies, staff may be asked to fill gaps which may arise from absence due to sickness or any other reasons.

- To support staff in this respect, consideration will be given to providing advance skills training or updates.
- In order to maintain service delivery and patient care, it may be necessary to redeploy staff at short notice.
- Trainees may be deployed to alternative duties within their prevailing skill sets at the time.
- Where trainees such as student paramedics have previously worked elsewhere in the Trust, particularly within EOC, they may be redeployed to their previous role/function.
- Volunteer staff from non-operational roles will be given the opportunity to train as call-takers to support EOC.

**Retirements/other former members of staff**

The possibility of re-employing recently retired staff and other leavers may provide a pool of potential staff to boost workforce numbers and resilience.

- The Trust will review the list of all staff who have left the Trust in the last two years with a view to exploring the possibility of inviting them to return to work.
- In such cases the same considerations as outlined in the previous section should apply.

**Bank/volunteer arrangements**

- The Trust has advertised for additional bank staff
- Availability for work of all those currently registered on the bank will be confirmed.
- Consideration will be given to utilisation of VAS staff.
- Mutual aid arrangements with other ambulance trusts will be explored.

**Working Time Provisions**

- The Trust will endeavour to abide by the requirements and the spirit of the European Working Time Directive.
- Where this would or could compromise service delivery or patient care, then it may be necessary to e.g. exceed weekly working limits for a period.
- Agreement with staff side to an extension of the reference period for calculation of working hours from 17 to 52 weeks will be sought.
- Individual “opt-outs” will be considered.
- Any variations to normal working time arrangements will only remain in place for the duration of the pandemic.

(N.B. National guidance on the EWTD and ambulance trusts is awaited.

**Travel Disruption**

The Trust will develop a formal policy to cover situations where staff are genuinely prevented form travelling to work due to disruption to public transport or fuel supply etc. Consideration will include:

- Car share arrangements
- Provision of transport
- Provision of accommodation
- Working from alternative locations, by agreement

9.13 These arrangements will be subject to regular joint review and may change.

## 10. Operational logistics resilience

10.1 Ambulance Service Trust procurement arrangements for the goods/products used across Ambulance Trusts - in particular business critical items - are in the main relatively generic. These include obvious areas such as vehicle fuel, medical gas (oxygen) electricity supply (for 999 call centre operation) and vehicle parts such as tyres and brake components which can all significantly impact on the ability of the service to continue to operate effectively.

10.2 It is assessed that there are some key actions with logistics and operational support arrangements that must be maintained to ensure the provision of service during periods of increased demand.

10.3 The London Ambulance Service has identified our critical supply chains in the following areas :

- Continuous supply of medical consumables
- Maintain continuity of medical gas supply
- Maintain continuity of supply of vehicle critical maintenance parts
- Vehicle maintenance and repair staff and facilities
- Vehicle fuel supplies
- Utility supplies (electricity, gas and water)
- Supply of Pandemic Flu specific consumables (eg FFP3 Masks)
- Continuous supply of ambulance medicines/drugs
- Adequate levels of procurement and logistics staff to ensure ability to process purchase order through to delivery functions

10.4 The London Ambulance Service has sought to obtain copies and test where appropriate business continuity plans for our critical supply chain suppliers and any third party sub-contractors/suppliers.

10.5 The Trust has conducted a review of its current stockholdings and initial business continuity arrangements for Ambulance consumables and has now put in place stockpiles of regular use (including drugs) and pandemic flu consumables for a total period of 3 months.

10.6 In addition, stocks of vehicle maintenance parts such as wheels and tyres, and routine maintenance service items such as brake and clutch component stock levels and other parts that would otherwise render the vehicle unserviceable, have been increased.

10.7 These arrangements will be co-ordinated by the Head of Operational Support.

## 11. Establishing a National Ambulance Service Coordination Centre (NCC)

11.1 The purpose of this section is to scope the need for a National Ambulance Coordination Centre to be established in the event of significant disruption to normal ambulance service provision. The centre would be activated once a set of pre-determined triggers were breached and its purpose would be primarily three fold, firstly to maintain a database of information detailing the levels of pressure in the system for each trust, secondly to coordinate requests for mutual aid between ambulance trusts and thirdly to provide a conduit between ambulance trusts and DH to highlight problems and disseminate agreed solutions.

11.2 Since the merger in July 2006 of Ambulance Services across England the need for mutual aid and support has not been called upon in quite the same way as it was previously. This has been due to the fact that the merged Trusts have an inherent greater capacity to absorb demand and cope with untoward issues than the previous individual ambulance services. However it is clear that there are still times when mutual aid might well be required and that this may also need some form of national coordination. Incidents such the flooding of 2007, the snow falls in 2009 and more recently pandemic flu all present challenges regarding the provision of mutual aid. Pre-planned events such as G20 and ultimately the Olympics simply add to the need for national coordination. There will also be a need to ensure that Scotland, Wales and Northern Ireland are also integrated partners in such arrangements should cross border support be required.

11.3 The National Director of Operations Group (NDOG) has largely been providing this function on an ad-hoc basis since 2006 and indeed has already developed a comprehensive Memorandum Of Understanding (MOU) regarding the provision of mutual aid which all the English Ambulance Trusts have signed up to as have Scotland and Wales.

11.4 Events such as the flooding of 2007 and the heavy snowfall in Feb 2009 have triggered National Conference Calls led by the chair of NDOG to ascertain the levels of pressure that each trust has been under and to arrange mutual aid if required.

11.5 The Swine Flu Pandemic of 2009 has prompted some further consideration as to whether the current arrangements go far enough or indeed should be formalised to provide better levels of support as we approach the winter of 2009/10.

11.6 This strand of work has now been incorporated into some national Winter/Flu operational planning led by Hayden Newton CEO for East of England and the work stream is being led by Martin Flaherty Deputy CEO of London Ambulance Service.

11.7 Section 11 sets out the role and function of a National Coordination Centre for Ambulance Trusts UK wide and the specific working arrangements. It should now be considered as a final draft and has been circulated to all National Directors of Operations for comment and input. It is anticipated that it will be formally signed off by the NDOG Group at its meeting on 20th August and will then be embedded in the 2009/10 National Winter/Flu Framework due for completion by end August/early September.

11.8 It is vital that the centre has a tightly controlled and pre-agreed accepted function. Whilst inevitably there may be a desire to extend its remit within a crisis situation this cannot be allowed to happen in an uncontrolled fashion.

11.9 It should be noted that the centre will have no role in intervening in how situations are being managed locally by individual trusts and will not be reporting information back to local SHAs or Commissioners.

11.10 The NCC will not be in operation routinely and will be established in response to a pre-agreed set of Triggers which are described later in this document.

11.11 The functions detailed below should be considered to be its core role from inception and they will only be extended following a period of further consultation and agreement with all Ambulance Trusts UK wide.

11.12 The centre will collect information on pressure levels within ambulance trusts across the UK. This information will be collected daily against a pre-agreed template and used to populate a database/spreadsheet. This information will then be fed back to all ambulance trusts in summary form together with a number of external stakeholders.

11.13 The purpose will obviously be to collate a national picture of pressure in the system, to look for developing trends and give some early warning of potential problems which can then trigger mitigating actions.

11.14 The following information will be collated for each Trust.

- Current REAP levels.
- Activity levels based as a % above or below each trusts norm for that month.
- Sickness levels within Field Operations and within Control Rooms
- Ambulance and Fast Response Unit availability levels as a % of normal plan.
- Hospital Turnaround Delays (metric to be developed)
- Fleet Availability based as a % of normal plan.
- Availability of specialist assets HART/USAR and CBRN as a % of Norm.
- Requests for Mutual Aid either in place or being considered.
- Supply chain issues

11.15 A template for collection of the data and guidance notes for each item in terms of metrics will be developed in due course.

11.16 Collection Methodology

- Each service will make a return against the pre-agreed template to a dedicated e-mail address by 10.00hrs each day.
- Information will be collated and a national summary sheet prepared which will be e-mailed back to Trusts by 12.00hrs each day.
- Deputy CEO LAS will then chair a national conference call with Directors of Operations at 13.00 each day to clarify/augment any information as required and to discuss any requests for mutual aid.
- The summary information will then be shared with DH ,the National Director of Ambulance Services DH and the devolved administrations by 1430hrs each day.
- It will be the responsibility of local ambulance trusts to continue to share information with their local health economy as appropriate.

11.17 It is anticipated that there will also be a role for the unit to gather intelligence on a wide range of issues including problems which ambulance trusts may be experiencing with other elements of the UK response to Pandemic Flu These might include for example interactions between the Pandemic Flu Service and NHSD with the 999 system or issues associated with the availability of vaccinations and anti-virals for ambulance staff.

11.18 Such issues will be fed into DH and the Ambulance Chief Executives Group (ACEG) as appropriate and any decisions taken as a result will be disseminated nationally via the NCC conference calls.

11.19 Requests for mutual aid will be made through the NCC and will then be organised in accordance with the national Memorandum of Understanding Concerning the Provision of Mutual Aid. This document was developed by the NDOG group within the last two years, clearly sets out the procedure for arranging mutual aid and has been used successfully within the last year to provide significant mutual aid for the London G20 event. All English Ambulance Trusts, Wales, Scotland and Northern Ireland have been involved in developing the document and are signed up to its principles.

11.20 The National MOU has been reviewed to ensure that it adequately covers all of the potential associated with the pandemic and is appended to this document.

11.21 Requests for mutual aid concerning the pandemic will be made directly to the National Coordinating Centre and then managed through the National Directors of Operations Group.

11.22 It should be noted that whilst all Ambulance Trusts have in principal signed up to the provision of Mutual Aid as per the national MOU there will be a need for the Ambulance Chief Executives Group (ACEG) to give additional delegated authority to the Deputy CEO of LAS in his capacity to oversee the NCC to require individual Trusts to provide that aid within a pandemic flu situation. All such requests will be discussed with NDOG and care will be taken to ensure that they are commensurate to the individual pressures that trusts are facing at the time.

11.23 Trusts will also need to gain their local Commissioners and SHA support for the provision of mutual aid under these arrangements.

11.24 It is envisaged that the NCC will be formed in response to the following triggers:

- One or more Ambulance Trusts declare REAP 5 or above (Potential Service Failure)
- One or more Ambulance Trusts requests Mutual Aid
- A direct request from ACEG on the recommendation of NDOG in response to widespread pressure which falls short of the above two triggers.

11.25 The centre will be stood down when a decision is reached by NDOG that it is no longer required.

11.26 The NCC will be based at the London Ambulance Service HQ at 220 Waterloo Road SE1 and once triggered will operate nominally for 12 hrs per day from 0800hrs to 20.00hrs.(these hours will of course be subject to review depending on circumstances prevailing at the time).

11.27 East of England have also agreed to provide a backup facility for the NCC within their accommodation in Bedford.

11.28 The Centre will be overseen by the Deputy CEO LAS or nominated Ops Director lead if unavailable.

11.29 In addition four staff will routinely be required to run the centre consisting of:

- A Senior Ambulance Operational Manager of Assistant Director level rank or equivalent
- An Emergency Planning Advisor
- An Administrative Support Manager
- A Management Information Analyst (Input as required)

11.30 LAS has committed to providing staffing for the first four days of operation once triggered. Assistance will then be required from each ambulance trust to maintain the operation beyond four days. These staff will be nominated as far as possible in advance and will be supplied on a rota basis. In order to ensure continuity each trust will be required to commit staff for a four day period. An appropriate handover must take place with the team leader (ADO) of the incoming team to ensure continuity.

11.31 In order to spread the load it is not envisaged that individual trusts will not be asked to provide all four staff for the team and indeed there may be advantages to having mixed teams with staff from across the country.

11.32 It is accepted that if the hours or remit of the NCC are extended then more staffing may be required.

11.33 It will be the responsibility of supplying trusts to cover all costs associated with the deployment of their staff to the NCC. LAS will however arrange accommodation if requested.

11.34 LAS has already secured accommodation within its HQ building at Waterloo and is currently equipping it with suitable IT systems etc. It is envisaged that this will be available if required from September and could be maintained through to end March 2010.

11.35 The centre will provide the following:

- Office Accommodation for four staff
- Dedicated separate room for Conference calls etc.
- Access to other meeting rooms as required
- PCs/Printers/Fax/Copiers
- Dedicated incoming telephone lines
- Conference call facilities
- Dedicated e-mail addresses
- General Administrative support
- Video Conferencing

11.36 The following linkages will need to be functioning well in order for the NCC to be effective:

- Department of Health
- National Director of Ambulance Services DH
- Ambulance Chief Executives Group (ACEG)
- National Ambulance Directors of Operations Group (NDOG)
- National Ambulance Emergency Preparedness Board (EPB)

- National Ambulance CEO Winter Planning lead
- Devolved Administrations

11.37 Agreement will need to be reached on the provision of funding to cover the costs of establishing and running the NCC.

11.38 The London Ambulance Service will incur set-up costs and much of the on-going running costs. It is proposed therefore that each ambulance trust covers the costs associated with seconding its own staff to the unit and that in addition a small contribution (to be agreed) is made to a central fund which will then cover all remaining costs. Trusts should ensure that all costs incurred which relate to the NCC are captured for later submission to an overall costing exercise for Pandemic FLU which will be coordinated by the Strategic Programme Delivery Board.

## 12. Communications Strategy

12.1 The way in which the London Ambulance Service manages the delivery of its services this winter could have a significant impact on its reputation, particularly if it is faced with unprecedented increases in demand and high levels of staff absence as a result of a flu pandemic.

12.2 If the Service reaches the REAP levels of 5 and 6, the actions that will be triggered will be beyond the expectations of many people.

12.3 The Service's communication plan is aligned with the national communication framework for winter and flu.

12.4 It focuses on four areas of communication and engagement activity:

- General winter and flu communication
- Pressure-related communication
- Business continuity planning for the communications team
- Post incident and recovery communication.

**Aims and Objectives**

12.5 The aim of communication and engagement activity is to help manage the demand on the Service during the winter so that it is in a position to continue providing care to the most seriously ill patients.

12.6 Effective communication and engagement will be critical to the reputation of the Service if significant increases in demand are experienced during this period.

12.7 The Service must also ensure that it fulfils its duty under the Civil Contingencies Act in warning and informing the public.

12.8 This will be achieved through the following objectives:

- To provide staff and the public with health advice, including information on keeping well.
- To inform the public about making the right choices to access care if they are unwell.
- To explain the Service's plans for dealing with increased pressures and how it will respond within the constraints that it will face, particularly if it reaches pressure levels 5 and 6.
- To gain support from key stakeholders, particularly NHS stakeholders, for the proposed measures that will be taken if pressure levels increase significantly.

- To encourage users of the Service to take action that will help reduce pressure on the 999 system.
- To inform staff in the event of operational difficulties of the role they can play to maintain levels of service.
- To recognise the challenges faced by staff during high demand and the contribution they are making to maintaining levels of service, and support them in this.

**Audiences**

12.9 Listed below are the key audiences that the Service must engage with during the preparation and execution of its winter plans.

12.10 Internal

- Staff:
  - executive team
  - managers (operational)
  - managers (departmental)
  - frontline staff – A&E, patient transport service and non-emergency staff
  - control room staff
  - support staff
  - communication, PALS/patient experiences teams
  - volunteers/community responders
- Unions
- Non-executive directors

12.11 External

- General public including:
  - Foundation trust members
  - Local involvement networks (LINks)
  - Patients (via staff)
  - 999 callers who do not need an ambulance response
- Patient groups
- Nursing homes
- Strategic health authority (NHS London) and commissioners
- Acute hospitals
- NHS Direct
- MPs, health overview and scrutiny committees and local authorities
- Other emergency services
- Voluntary and private ambulance services, and HEMS
- Voluntary agencies

- London Resilience Forum
- Media
  - BBC – connecting in a crisis
  - local, regional and national media
  - online media
  - trade press eg Health Service Journal

**Messages**

12.12 The top-line message must focus on the need for the Service to be in a position to continue to deliver the best possible care to the patients that really need it.

12.13 Detailed messaging will be developed to address a number of areas.

General winter/flu messaging:

- Appropriate use of NHS services (when and how to access different care)
- Keeping well over winter.
- Flu messages - knowing how to reduce the risk of flu, and what to do if you catch flu.
- How the Service is planning for winter.
- What response to expect from the Service.

12.14 Pressure-related messaging:

- What levels of demand the Service is facing and how it is managing it.
- The Service's priority to provide an emergency response to people who have life-threatening illnesses or injuries.
- Aligned to activity when different pressure (REAP) levels are triggered.

**Tactics**

12.15 There are four areas of communication and engagement activity:

- **General winter/flu communication**
  Activity that the Service should carry out in the run-up to/during the winter period, regardless of pressure levels.
- **Pressure-related communication**
  Communication activity to explain the Service's planning and the activity that will take place as operational pressures increase. This will be aligned with the REAP levels.
- **Business continuity within communications team**
  To enable the communications team to meet their priorities as demand and staff absences increase.
- **Post incident and recovery period communication**
  To ensure continuing communication and debriefing during the recovery period.

12.16 A pool of media spokespeople will be identified and trained to speak on winter-related issues.

12.17 It is suggested clinical leads speak on proactive health issues and operational leads address pressure/resource issues. The NHS Confederation/Ambulance Service Network (ASN) will be asked to speak at a national level on the ambulance services' ability to cope.

**General Winter and Flu Communication**

12.18 External communication:

12.19 External communication activity will be integrated with the communication plans of the Department of Health, NHS London and local primary care trusts.

12.20 Planned communication is detailed below.

| **Health promotion – keeping well and choosing well this winter** | |
|---|---|
| Promotional material providing health advice and how to choose the right health care | Guidance will be sought on what approach the Department of Health and NHS London are planning to take around health promotion this winter. It is essential that ambulance-related messages are incorporated in any joint agency campaigns, specifically when to call 999 and what to expect from the ambulance service.<br><br>The Service will consider producing ambulance-led material, for example leaflets/z-cards, posters. |
| Media campaign | Keep warm, take medication, flu prevention and treatment. Based on 'keep well, choose well' messaging. |
| Ambulance decals | These will be developed for the sides of ambulances and will carry winter-related messaging. |
| Social media | Initial research has shown that most of the patients who call 999 but whose enquiries are resolved through clinical telephone advice/NHS Direct are women aged between 19 and 35.<br>This audience tend to use social media and could be targeted through internet advertising eg on Facebook, Twitter, YouTube. |
| Letter to 999 callers | Letter to 999 callers who do not require an ambulance. Focus on keep well advice over winter with messages |

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| | about when to call 999, and insert health promotion material. (Depends on whether patient details can be extracted from records). |
| Other communication channels for consideration | Media advertising - radio, press (would be more cost effective if this was used in a joint health advertising campaign).<br>Community TV/Life Channel.<br>Via external ambassadors such as patient representatives, volunteers, councillors.<br>Via staff champions. |
| **Other seasonal issues** | |
| Media campaign | Advice on sensible drinking during the festive season, and when and how to use the 999 service. |
| Media campaign | Promote local initiatives for dealing with alcohol-related calls eg 'booze bus', mobile treatment tents. |
| Media campaign | Cold weather guidance eg driving safely, looking after vulnerable people (linked with 'keep well, choose well' messaging). |
| **Service's planning for winter and flu** | |
| Stakeholder engagement | Brief key stakeholders on winter/flu plans.<br><br>Detailed briefings:<br>- Department of Health<br>- NHS London<br>- Commissioners<br>- London Resilience Team partners inc police and fire<br><br>Issue-specific briefings:<br>- Voluntary and private ambulance services<br>- Voluntary agencies eg British Red Cross<br>- Acute hospitals<br>- NHS Direct<br>- Nursing homes<br><br>General briefings:<br>- MPs<br>- Local authorities<br>- Health overview and scrutiny committees |

12.21 Internal communication:

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| **Health promotion – keeping well this winter** | |
| Seasonal flu/H1N1 vaccine | Encourage staff to have these vaccinations. |
| Keeping well | General advice on how to avoid getting flu and keeping well. |
| Infection control | How to reduce risk of infection when dealing with patients. |
| **Planning for winter** | |
| Understanding the plans and implications | Ensure staff at all levels are aware of the predictions for winter, the challenges that are expected, and the role they will play in delivering levels of service. |
| Providing support | Invite expressions of interest from staff who are prepared to undertake training so they can take 999 calls if demand increases significantly. |
| **Communicating with the public and patients** | |
| Key messaging | Staff to understand and be able to communicate and explain the key messages to patients and the public on request including 'keep well, choose well' messaging.<br>Staff to be provided with media relations guidance. |

12.22 Existing channels should be used for communicating and engaging with staff pre and during the winter period, bearing in mind that face-to-face communication is the most effective method:

- Station meetings
- Consultation meetings/staff conferences
- Operational meetings/briefings
- Use of Q and As to explain topics
- Video interviews published on the intranet
- Podcasts
- Staff champions
- Bulletins
- Letter from the chief executive
- Intranet
- Internal magazines
- Mobile data terminal messaging/text messaging
- Visibility of the REAP levels

**Pressure-related communication**

12.23 Communication activity will increase as higher pressure levels are triggered within the Resource Escalation Action Plan (REAP).

**REAP level 1 to level 3 (Routine – Moderate pressure)**

12.24 During this period it is anticipated there will be minimal internal or external pressure-related communication activity; the focus will be on researching baseline statistics. In the run-up to winter work will focus on developing messaging around keeping well and choosing well, and explaining the Service's plans for winter.

| **Role of communications department** | |
|---|---|
| General winter/flu communication | • Maintain proactive public communication through 'keep well, choose well' messaging and staff communication. |
| Situation awareness | • Monitor situation and ensure department is kept informed of developments or reasons for increase in demand. |
| | • Monitor external situation eg whether any weather warnings are given that could impact further on the situation. |
| Statistics | • Research the following:<br>- How demand has increased this year compared to last year (no of calls received and attended)<br>- Benchmark statistics relating to flu-like and respiratory symptoms (call rates during seasonal flu period)<br>- Anticipated increase in call rates and staff absence if there is a flu outbreak.<br>- Profile of callers who are dealt with through clinical telephone advice – could be targeted with messages at later stage. |
| | • Access current performance statistics. |

**REAP level 4 (Severe pressure)**

12.25 Communication activity will increase significantly when REAP level 4 is triggered. This may occur when week four of a pandemic wave is reached, and demand on the 999 service starts to rise. Current flu planning assumptions indicate that demand will escalate rapidly from this point, and higher REAP levels may be triggered very quickly.

| **Role of communications department** | |
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| Situation awareness | • Monitor internal and external developments (as at levels 1-3). |
| Statistics | • Access to current performance statistics. |
| | • Access daily data for call volume, response rates, conveyance rates, flu-related calls, staff absence levels, details of untoward incidents. |
| | • Have access to the following:<br>- How demand has increased this year compared to last year (no of calls received and attended)<br>- Benchmark statistics relating to flu-like and respiratory symptoms (call rates during seasonal flu period). |
| Gold meetings | • Communication representative to attend and advise on strategic communication issues. |
| | • Ensure communications department receives sit reps. |
| Communications team priorities | • Review business continuity plan. |
| | • Communications team to consider what support it can give to operations in the current situation. |
| | • Consider how workloads may be prioritised should pressure levels rise. |

| **Internal communication** | |
|---|---|
| Staff engagement | • REAP escalation level briefing with appropriate visibility. |
| | • Using internal communication channels to inform staff of current pressure situation and response, including what role staff play.<br><br>• Face-to-face channels:<br>- Station meetings<br>- Consultation meetings/staff conferences<br>- Operational meetings/briefings<br>- Staff champions<br><br>• Real-time channels:<br>- Mobile data terminal messaging<br>- Text messaging<br>- Airwave |

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| | - Email<br>- Intranet<br>- Bulletins/operations instructions<br><br>• Other channels:<br>- Visibility of the REAP levels<br>- Use of Q and As to explain topics<br>- Video interviews published on the intranet<br>- Podcasts<br>- Letter from the chief executive<br>- Internal magazines |
| | • Ensure recognition of staff work pressures. |
| Union engagement | • REAP escalation level briefing and request for support in staff engagement. |

| **External communication** | |
|---|---|
| Media relations | • Review pressure-related messaging for public and key stakeholders, and ensure reactive media statements are consistent with key messaging. |
| | • Issue media release to local and regional media and offer facilities for interview. |
| | • Offer ride-outs for media to see what types of calls are being received/what pressure the service is under. |
| | • Offer media facilities in the control room to see how calls are being managed. |
| | • Reinforce 'keep well, choose well' messaging. |
| Stakeholder engagement | • Brief key stakeholders on rising pressures. If REAP level 4 has been triggered because the flu pandemic has entered its fourth week, higher REAP levels may be triggered very quickly. Stakeholders need to be made aware of any potential for levels to increase.<br><br>Detailed briefings:<br>- Department of Health<br>- NHS London |

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| | - Commissioners<br>- London Resilience Team partners inc police and fire<br><br>Issue-specific briefings:<br>- Voluntary and private ambulance services<br>- Voluntary agencies eg British Red Cross<br>- Acute hospitals<br>- NHS Direct<br>- Nursing homes<br><br>General briefings:<br>- MPs<br>- Local authorities<br>- Health overview and scrutiny committees |

**REAP level 5 (Critical pressure)**

12.26 At REAP level 5, the Service may decide not to respond to any Category C calls, and at some point may not respond to some Category B calls. These calls will be referred to NHS Direct, giving the Service capacity to deal with the most seriously ill or injured patients.

12.27 It is possible that a major incident will be declared when reaching this level of pressure.

| **Role of communications department** | |
|---|---|
| Implement communication crisis plan | • Implement crisis plan if situation is declared a major incident, ensuring roles and responsibilities are allocated, key messages are confirmed and a dedicated media spokesperson is identified and briefed. |
| Situation awareness | • Monitor internal and external developments (as at levels 1-3). |
| Statistics | • Access to current performance statistics. |
| | • Access daily data for call volume, response rates, conveyance rates, flu-related calls, staff absence levels, details of untoward incidents. |
| | • Have access to the following:<br>- How demand has increased this year compared to last year (no of calls received and attended)<br>- Benchmark statistics relating to flu-like and respiratory symptoms (call rates during |

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| | seasonal flu period). |
| Attendance at local Gold meetings | • Communication representative to attend and advise on strategic communication issues. |
| National ambulance coordination centre | • Communications team to link in with and receive sit reps from the centre. |
| | • Comms rep to dial into teleconferences where appropriate. |
| Inter-agency communication | • Liaise with other London Resilience Team communication leads. Note that the London Ambulance Service communication lead is the deputy chair for pandemic-related issues.<br>• Liaise with national ambulance communication leads. |
| Communications team priorities | • Invoke business continuity plans if appropriate |
| | • Ensure workloads are prioritised so that communications team can support operational pressures. |
| | • Request mutual aid arrangements from other communication teams if needed. |

| **Internal communication** | |
|---|---|
| Staff engagement | • REAP escalation level briefing with appropriate visibility. |
| | • Use real-time communication channels to issue critical, key messaging to frontline staff:<br>- Mobile data terminal messaging<br>- Text messaging<br>- Airwave<br><br>Also consider the following channels for other staff groups:<br>- Email<br>- Intranet<br>- Bulletins/operations instructions |
| | • Using other internal communication channels to keep staff updated on current pressure situation and response, including what role they play:<br><br>- Station meetings<br>- Consultation meetings/staff conferences |

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| | - Operational meetings/briefings<br>- Staff champions<br>- Visibility of the REAP levels<br>- Use of Q and As to explain topics<br>- Video interviews published on the intranet<br>- Podcasts<br>- Letter from the chief executive<br>- Internal magazines |
| | • Ensure recognition of staff work pressures. |
| Union engagement | • REAP escalation level briefing and request for support in staff engagement. |

| **External communication** | |
|---|---|
| Media relations | Review pressure-related messaging for public and key stakeholders, and ensure reactive statements are consistent with key messaging. |
| | • Brief key journalists on the current situation. |
| | • Issue media release to local and regional media and offer facilities for interview. Local stats will be needed, possibly on a daily basis. |
| | • Reinforce 'keep well, choose well' messaging. |
| | • Deal with potential increase in delay stories. |
| | • If intelligence suggests move to REAP 6, prepare news conference or interviews (via pooling arrangement). Provide the media with video and audio clips where appropriate. |
| | • Seek support from Department of Health and NHS Confederation on messaging. |
| Website | • Maximise use of the website to convey messages. Consider triggering the major incident website. |
| Stakeholder engagement | • Brief key stakeholders on rising pressures.<br><br>Detailed briefings:<br>- Department of Health<br>- NHS London<br>- Commissioners<br>- London Resilience Team partners inc police and fire |

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| | Issue-specific briefings:<br>- Voluntary and private ambulance services<br>- Voluntary agencies eg British Red Cross<br>- Acute hospitals<br>- NHS Direct<br>- Nursing homes<br><br>General briefings:<br>- MPs<br>- Local authorities<br>- Health overview and scrutiny committee |
| | • Brief key stakeholders in advance if there is an indication that REAP level 6 is to be triggered:<br><br>Detailed briefings:<br>- Department of Health<br>- Strategic health authorities<br>- Commissioners |
| Patient experience | • Review PALS enquiries and complaints relating to pressures and brief media team accordingly. |

**REAP Level 6 (Potential service failure)**

12.28 At REAP level 6, the Service will only respond to critically-ill patients. All other calls will be referred to NHS Direct.

12.29 At this level the Service will have declared a major incident.

| **Role of communications department** | |
|---|---|
| Implement communication crisis plan | • Implement crisis plan if situation is declared a major incident, ensuring roles and responsibilities are allocated, key messages are confirmed and a dedicated media spokesperson is identified and briefed. |
| Situation awareness | • Monitor internal and external developments (as at levels 1-3). |
| Statistics | • Access to current performance statistics. |
| | • Access daily data for call volume, response rates, conveyance rates, flu-related calls, staff absence levels, details of untoward incidents. |

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| | • Have access to the following:<br>- How demand has increased this year compared to last year (no of calls received and attended)<br>- Benchmark statistics relating to flu-like and respiratory symptoms (call rates during seasonal flu period). |
| Attendance at Gold meetings | • Communication representative to attend and advise on strategic communication issues |
| National ambulance coordination centre | • Communication representative to attend and advise on strategic communication issues. |
| | • Communication team to link in with and receive sit reps from the centre. |
| | • Comms rep to dial into teleconferences where appropriate. |
| Inter-agency communication | • Liaise with other London Resilience Team communication leads. Note that the London Ambulance Service communication lead is the deputy chair for pandemic-related issues.<br>• Liaise with national ambulance communication leads. |
| Communications team priorities | • Business continuity plan fully implemented. |
| | • Ensure workloads are prioritised so that communications team can support operational pressures. |
| | • Seek mutual aid from other ambulance communication team if needed. |

| **Internal communication** | |
|---|---|
| Staff engagement | • REAP escalation level briefing with appropriate visibility. |
| | • Restrict internal communication activity to service critical messaging only. |
| | • Use real-time communication channels to issue critical, key messaging to frontline staff:<br>- Mobile data terminal messaging<br>- Text messaging<br>- Airwave<br><br>Also consider the following channels for other staff groups: |

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| | - Email<br>- Intranet<br>- Bulletins/operations instructions. |
| | • Broadcast video interview/podcasts with chief executive and other senior managers via intranet. |
| Union engagement | • REAP escalation level briefing and request for support in staff engagement. |

| **External communication** | |
|---|---|
| Media relations | • Seek support of Department of Health and NHS Confederation in issuing national lines to explain the extreme situation. |
| | • Operate as per crisis plan. |
| | • Review pressure related messaging to public and key stakeholders, and ensure reactive statements are consistent with key messaging. |
| | • Issue media releases (aligned to the three stages of REAP 6) to local and regional media. |
| | • Release statistics to media on daily basis. |
| | • Hold news conference and offer facilities for interview – taking account current guidance on infection control issues. Discuss pooling arrangements with media. |
| | • Deal with increase in patient complaint stories. |
| | • Consider issuing critical, immediate self-care advice and management, for example, cardiopulmonary resuscitation, burns, wound management (consider visual aids, use of website). |
| Website | • Trigger major incident website. |
| Stakeholder engagement | • Maintain a flow of information to key stakeholders by using teleconferencing or web briefings:<br><br>- Department of Health<br>- NHS London<br>- Commissioners |
| Patient experiences | • Review PALS enquiries and complaints relating to pressures and brief media team accordingly. |

**Business continuity within communications team**

12.30 The communications team's capacity will be affected by increased operational pressures, reduced staffing levels, or transport disruption. The team will be considered a critical function and it is inevitable that the level of demand for communication activity will increase significantly as the REAP level escalates.

| REAP LEVEL | ACTION |
|---|---|
| 1 – 3 | • Communications team to develop business continuity plans including staff mapping, prioritisation of workload and mutual aid arrangements. |
| 4 | • Monitor capacity and consider implementation of plan. |
| 5 | • Implement plan and mutual aid arrangements. |
| 6 | • Plan fully implemented and being monitoring. |

**Post incident and recovery period communication**

12.31 During a sustained period of severe pressure which may result in potential service failure, it is almost certain that there will be high levels of scrutiny, and long-term repercussions on the Service's reputation. It is important that plans are put in place to be able to respond to issues, requests for information, complaints and inquiries that will arise.

12.32 The communications team will maintain records and logs of all communication decisions and activities.

**Timescales**

12.33 General planning for winter and flu will start in September, and activity against the REAP levels will be implemented as the different pressure levels are triggered during the winter period.

12.34 A schedule will be developed for the deliverables of this plan.

**Budget**

12.35 Where possible communication activity will be carried out using existing staffing and financial resources.

12.36 Activity that will need additional funding includes health promotion materials, ambulance decals, and any media (including social media) advertising.

**Evaluation**

12.37 A template for evaluating communication activity through the winter will be developed.

## 13. Recovery Planning

13.1 As a result of a prolonged period of intense over capacity through the peak period of the flu pandemic, the Trust will be fatigued. Many staff will have been working additional hours to maintain, where possible, emergency services in line with national standards. Large numbers of staff will not have taken any annual leave for many months and many more will have accrued large amounts of time in lieu as a result of working additional hours during the second wave of the pandemic.

13.2 During the periods where REAP levels were elevated above REAP 3, routine activity such as training and development will have been deferred. There will be a large training deficiency that will need to be corrected in the months immediately after the pandemic.

13.3 Some non-essential activity within the Trust is likely to have been deferred during the pandemic, releasing staff normally retained in these areas of activity to support core systems and activities. As such there will be a lag time for these services to return to normal.

13.4 The post pandemic recovery phase will strategically be led in the first instance by the Trusts strategic flu group, this is likely to be as the demand for emergency ambulance services begins to fall but has not returned to seasonal norms.

13.5 As we begin to lower REAP levels and have returned to routine management of all incoming demand, routine activity will begin to return and staff that had been redeployed from non-business critical areas will return to their core duties.

13.6 When demand has returned to seasonal norms and REAP has been returned to a level below REAP 3, the recovery phase will be managed by the Director or Deputy Director of Operations. A gradual return to routine levels of training and planned abstraction will be managed through a weekly series of meetings with relevant heads of department and directorate leads. We will over a period of many weeks, manage a phased return to normality.

13.7 Due to the levels of fatigue that will be experienced within London Ambulance Service and the recovery period taking some three months to work through, national patient waiting time standards (response times) will not recover immediately. They will have been seriously damaged as a result of the second wave of pandemic flu or prolonged periods of adverse weather and associated demand increases and will not immediately recover to commissioned threshold levels.

## 14. Risks

**Patient Waiting Time Standards**

14.1 National patient waiting time standards (response targets) will be adversely affected by either prolonged periods of increased demand as a result of adverse weather or through the increased demand for emergency ambulance services as a result of the second wave of pandemic flu.

14.2 These increases in demand are predicted to be extreme and will have required draconian measures to protect, where possible, the provision of emergency services to immediately life threatened patients.

14.3 Large numbers of patients that would routinely have received an ambulance response would not have received one and instead would have been directed by London Ambulance Service to other health providers such as those in the community or NHS Direct. As a result there will be increases in demand for these services.

14.4 Modeling undertaken on behalf of the UK Ambulance Services Director of Operations group and the Department of Health sets out the impact of demand increases and reductions in available staffing, these are shown earlier in this framework document. They show dramatic changes to the waiting time standard that is most susceptible to changes in demand and capacity, Call Connect waiting times.

**Finance**

14.5 Preparations and planning for pandemic flu and adverse weather through the winter period of 2009/10 have placed additional financial burdens on the Trust.

14.6 Its has been necessary to procure additional PPE and stockpile items of equipment that we would not routinely hold. We have resourced the National Co-ordination Centre (NCC) and plan to staff it for the first seven days of operation. We will also continue to support the NCC with additional staff when sister Trusts from across the UK are unable to allocate staff.

14.7 We have a fulltime pandemic flu coordinator and have incurred additional costs associated with demand management advertising and staff communication.

14.8 Indicative costs associated with this additional activity have been collated.

14.9 During the peak weeks of the pandemic wave, it is likely that we will incentivise overtime working in an effort to attract as many staff as possible to work enabling us to mitigate the losses associated with staff sickness and career abstractions as set out in the

national planning assumptions. These incentives and the additional overtime working will not have appeared in this years budgets and will as a result place a substantial financial burden on the Trust.

14.10 If deployed, there will be significant additional costs associated with enhanced call taking arrangements supported by agency staff.

14.11 Collectively, these additional and unfunded financial pressures could place at risk year end financial balance.

**NHS and Ambulance Service Reputation**

14.12 There is a risk that certain patient groups, primarily those with less serious clinical presentation, will not receive an ambulance response during the periods of extreme demand as set out in this framework. These changes to service provision to protect the levels of service provided to those patients who are most seriously ill could potentially be seen as a failure of the service.

14.13 With extensive waiting times for 999 calls to be answered, elongated response times for emergency ambulances and delays at hospital emergency departments for ambulance crews to handover patients, the public perception could be one of a failing service.

14.14 The communications strategy in this framework is designed to inform the public of necessary changes in service provision as a result of significantly increased demand against a context of reduced staff availability. The communications strategy will set out the planning and preparation that has taken place and provide self help advice to the public asking them to use their emergency services wisely during times of unprecedented demand.

14.15 The strategy will ensure that all health providers in London and the UK ambulance services provide consistent information to the public.