London Ambulance Service NHS
NHS Trust

Our plans to improve the care we provide to patients

Dear Colleague

As a number of you have told me, it is increasingly apparent that we need to work differently to enable us to provide a safe and high-quality service to our patients in the future.

We also need to make the very best use of every penny we are given. And by working differently and more efficiently, we will be able to reduce the pressure on you at a time when demand on our Service continues to increase.

Part of doing things differently will also be about starting conversations across the whole organisation about how we engage with one another and what kind of ambulance service we want to be in the future.

This document explains some of the changes we are planning and why. We all have a part to play in making them happen, and I am keen to hear your views on how we achieve these changes in a way that sustains delivery of safe, high-quality services for patients and delivers an improved working environment for you, our staff.

I know that change can be difficult and may directly affect some of you. I want to assure you that we will do all we can to support you through this time of change.

Ann Radmore
Chief Executive

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The clinical case for change

The face of London is changing, healthcare is undergoing the biggest reconfiguration that has ever been seen, and the financial challenges facing the NHS are significant. At the same time, patient expectations and demand on health services are increasing.

As an emergency and urgent care provider, the London Ambulance Service has an ever increasing role to play in helping patients and supporting the delivery of the vision for healthcare in London and the wider NHS. This includes making sure we can play our part in the delivery of high-quality and safe care in London's acute emergency and maternity services as described in the London Health Programmes' case for change[1].

Against this background, we need to change how we use our workforce to ensure that the quality of care we provide to patients continues to improve whilst delivering it in a more efficient way.

This clinical case for change describes why we need to change, what we are going to change and what the London Ambulance Service will look like in 2015 for both our patients and our workforce.

Dr Fionna Moore
Medical Director

Steve Lennox
Director of Health Promotion and Quality

[1] London Health Programmes: 'London Quality Standards - Acute Emergency and Maternity Services'. February 2013

Why now?

Our staff, patients and stakeholders have been telling us for some time that we need to change, and we really need to do things that benefit patients and improve outcomes.

In addition, the recently published Francis report into the deaths at Mid Staffordshire NHS Foundation Trust highlighted that there are many issues which are a trigger for change for all NHS services.

Our Service is facing increasing levels of demand, with 999 calls into our control room up on last year and our staff responding to four per cent more incidents overall. We have been providing a good level of service to our patients with life-threatening illnesses and injuries, despite attending 12.5 per cent more of these patients. However, few of the patients who access emergency health services have life-threatening conditions. We know these patients need a response, and we are being asked to play our part in managing patients differently.

Whenever we can, we need to address a patient's needs at the point of contact and avoid taking them unnecessarily to hospital. But some of our patients who have less serious conditions and do need an ambulance response have to wait longer for our help than they should.

On a normal day, frontline staff spend over 85 per cent of their time dealing with patients, compared with 65 per cent in other ambulance services. Essentially, this means staff are extremely busy throughout their entire shift. And we recognise that our control room staff come under immense pressure when we are busy and are holding high numbers of calls.

As a result staff are feeling the pressure, and those who work on the frontline are not getting regular breaks during shifts and have difficulty being released for training.

With demand expected to continue to increase, it is clear that change is needed if we are to maintain a safe and high-quality service for our patients and good working conditions for staff in the future.

Significant changes within the NHS in England came into effect on 1 April 2013. Key amongst those changes is the fact that our services are now commissioned directly by GPs who both want and expect that we spend the money they give us wisely to ensure the best possible outcomes for their patients.

More broadly, we see the changed system as an opportunity to engage with the wider health and social care system and, as the sole pan-London healthcare provider, to become an influential voice in shaping the future of healthcare in London.

As services are being reconfigured across London and new services are developing, for example NHS 111, we must not only work closely with our partners, but we must also ensure that as an organisation we are appropriately resourced, with staff who are trained and equipped to deal with the challenges the future may bring.

The changes we are proposing will not happen overnight and they will be challenging. But, as we start to do things differently, we will see longer term benefits for both patients and staff. For patients this will mean they receive more appropriate and timely treatment from us, leading to better outcomes for them. Staff will benefit from being less busy and will have greater opportunities to increase their clinical skills through better access to education and development within a clearly defined career structure.

We believe that the proposed changes to our clinical workforce will provide Londoners with an ambulance service which, by 2015, can respond to their needs, and which staff can be proud to work for.

By 2015:

- Every patient who rings 999 will have a response within one hour – either by telephone assessment or an ambulance attendance.
- Our rosters will enable us to match ambulance availability with 999 call demand.
- We will have established close working relationships with clinical commissioning groups to identify gaps in service and improve access to appropriate healthcare options.
- Patients will experience a seamless referral to appropriate providers, for example, NHS 111, crisis and falls teams.
- Every patient who requires a face-to-face assessment will be attended within an hour by a paramedic with enhanced assessment skills who has the right training and experienced clinical support.
- On scene senior clinical support will be provided to staff where needed.
- Staff will benefit from an embedded clinical career structure, education and regular meaningful feedback and appraisals.
- We will be less reliant on private and voluntary ambulance services as we will have recruited more staff.

Three questions

In considering whether and how we need to change the way we deliver our services in the future, we asked ourselves three questions:

- How can we change the way we deliver ambulance services to improve the quality of care and outcomes for all patients?
- How can we ensure that every patient who rings 999 receives a response in a clincally appropriate time?
- Is no change an option?

Currently not all our patients receive as timely and appropriate a response as they should; an example of this is Emily.[2]

Emily's story

Emily lives alone and is frail, elderly and vulnerable. For her, every day that she manages to maintain her independence is a day to celebrate. But today she is lying on the floor having tripped over a loose carpet. This is not the first time she has fallen. She is anxious that the authorities will assess her as vulnerable and admit her to a care home because she can no longer cope.

Emily doesn't know who to call for help. Her daughter lives some miles away and she can't reach her address book. Finally, she grabs at the telephone cord to drag the phone over and dials 999.

She asks for an ambulance, answers a set of questions, and waits. As time passes Emily notices the daylight fade. The electric fire is in the other room and she is becoming colder with every passing minute.

To Emily, it seems a terribly long time since she called 999. Initially she is able to fight off the thought she may have been forgotten, but as time passes she fears being left to die on the floor.

Truly frightened, cold and tired she dials 999 once more.

Our ambulance crews finished their busy shift 30 minutes early as they have not had a break during the day. We have

[2] All patient stories are based on real events although names and some details have been changed to protect their identities.

no resources available because calls to people with life-threatening illnesses and injuries are up six per cent.

Our clinician in our 999 control room grows increasingly concerned about Emily, aware that elderly fallers who wait more than an hour for help have a significantly worse outcome.

Eventually an ambulance crew are sent who are very caring and supportive to Emily. After a full assessment they do not find any injury or acute medical problem. They try to refer Emily to a falls team or her GP, but given the time of day they are unable to do so. Emily is, therefore, taken to hospital.

Our staff will be very familiar with Emily's story. There is a widening gap between the response time and care that we provide to our most seriously ill and injured patients, and those whose clinical need is initially assessed as less urgent.

Every day patients with no immediately life-threatening symptoms will wait too long for help, and every day patients or their relatives tell us of their experience. Every week our frontline staff raise concerns relating to delays in reaching patients, and every month we investigate one or two serious incidents where patients have waited too long for help.

Would you be happy with this response and care if Emily was your mother or grandmother?

We believe that every patient who needs an ambulance should receive one in a time frame appropriate for their condition, and no one should wait more than one hour for either an enhanced telephone assessment or an ambulance.

Responding to non life-threatening urgent calls

Some of the care we provide is excellent and amongst the best in the world. We have proven we can deliver change, for example, through working with other health partners to introduce London's trauma, cardiac and stroke networks.

We respond extremely quickly to calls that are prioritised as life-threatening or an emergency, but every patient who dials 999 and requires an ambulance should receive one in a timescale appropriate to their clinical need.

We know that some healthcare professionals believe we over triage our calls and that, if we addressed initial telephone assessment, we could use our resources more effectively. We are very aware that the patient who is ringing 999 believes they are in an emergency situation. It is our responsibility to assess their clinical need and deal with their call in the most appropriate way.

Not every 999 call needs an ambulance within eight minutes, but every patient should get a response either face-to-face or by telephone within one hour. By 2015, every patient needing a face-to-face assessment will be attended by a paramedic with enhanced assessment skills who has the right training and experienced clinical support.

Our cardiac arrest patients have the best outcomes in England. The outcomes for our less sick and seriously injured patients must be to the same high standard.

Relayed by a friend, this is the story of a cyclist who received a delayed response from us.

A cyclist's story

"I rang your service to request an ambulance for a friend of mine who had fallen off his push bike and had obviously damaged his leg. We later found out he had dislocated and fractured his ankle.

"He was in extreme pain and got very cold as he was lying on the pavement. We waited for over an hour having been told that no estimated arrival time could be given.

"In desperation, as I feared hypothermia was setting in, I flagged down a fire engine. They were of great help and support. They too rang for an ambulance and fortunately one arrived within 10 minutes.

"Once they arrived on scene the ambulance crew were excellent and professional and after treating my friend on site we were taken to hospital."

Whilst we have some of the lowest number of complaints on issues such as privacy and dignity in the whole of London, those about delayed responses now account for 40 per cent of our total complaints.

We respond to a significant number of our patients categorised as C1 or C2 within one hour (either with an ambulance or a telephone assessment), but too many of our Category C3 and C4 patients wait for over an hour and often much longer for a response.

Call categories and examples

Category A: Immediately life threatening needing an ambulance response within eight minutes – for example, a patient in cardiac arrest.

Category C1: Include diabetic patients who are confused due to a low blood sugar, requiring an ambulance response within 20 minutes.

Category C2: Traumatic injuries with no primary symptoms (for example, patients who are conscious and able to talk, and with no evidence of serious bleeding), needing an ambulance response within 30 minutes.

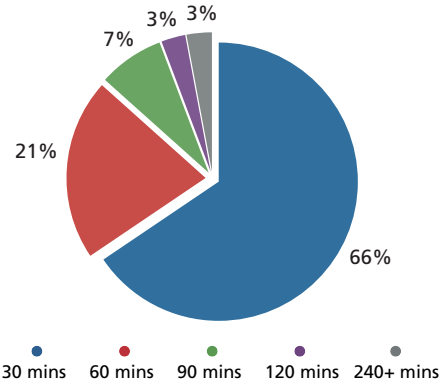
Category C3: Include some abdominal pains and headaches where the patient is fully alert, requiring an enhanced telephone assessment within 30 minutes.

Category C4: Include minor cuts, nosebleeds and back pain with no injury, needing an enhanced telephone assessment within 60 minutes.

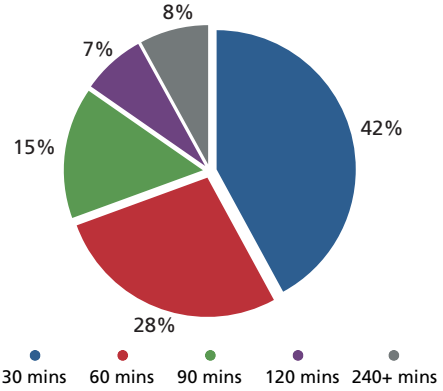
These lengthy waits can, and do, lead to patients becoming distressed and potentially more unwell. In some cases, this will also impact on their families and friends.

As patients become more anxious waiting for an ambulance, they understandably call us back. This increases the workload on our call handlers and the risk of a delay in answering a Category A call.

Category C3 response times (mins)



Category C4 response times (mins)



Last winter, some of our mental health patients waited up to six hours for a response. The distress and anxiety this causes to the patients and their carers is difficult to quantify, but the complaints we receive serve as a reminder that this is a real issue. Take Daniel's story for example.

Daniel's story

Daniel has a history of depression. He is feeling particularly vulnerable and even the routine elements of the day, such as dressing and eating, are simply too much. He feels a complete burden and utterly helpless and today he is unable to see a way out.

It is a bank holiday weekend and Daniel's usual community team are not contactable. He is unaware of how to contact a crisis team. His friends have gone away for the weekend and Daniel does not want to burden them.

Daniel becomes desperate – he does not know who to contact for help. He turns to Facebook to share his thoughts and feelings with friends.

Luckily a friend reads his online posts and contacts Daniel to persuade him to call 999 for an ambulance.

Daniel eventually calls us and he gives a vague history of feeling anxious at the point of the call – he finds it difficult to verbalise his distress. After being assessed, he is allocated a 20-minute response as our call-taker is concerned for his welfare. The lack of clarity of the problem made this call unsuitable for transfer to NHS 111. Twenty minutes pass, 30 minutes, then 40 minutes. We are still unable to identify a resource to send to Daniel. Our

clinicians within the control room try to contact him to check on him.

Concerned that Daniel doesn't answer our call, the clinicians upgrade the initial call to an emergency, requiring an eight minute response. A resource is assigned but gets cancelled to attend a cardiac arrest. We finally reach Daniel 90 minutes after his first call.

So how do you think this story ended?

There are several possible outcomes to this real life story. Daniel could have taken an overdose which, in addition to the mental distress he was suffering, may have meant he needed medical attention before a mental health assessment. But, if Daniel had not harmed himself, did he need to be taken to a busy emergency department?

By 2015 we will have established reliable ways to access alternative healthcare options that provide the most appropriate care for patients in the right place, at the right time.

By 2015:

- Every patient who rings 999 will have a response within one hour – either by telephone assessment or an ambulance attendance.
- We will have established close working relationships with clinical commissioning groups to identify gaps in service and improve access to alternative healthcare options.
- Patients will experience a seamless referral to appropriate alternative providers, for example, NHS 111, crisis or falls teams.
- Every patient who requires a face-to-face assessment will be attended by a paramedic with enhanced assessment skills who has the right training and experienced clinical support.

A skilled clinical team

If we are to deliver high-quality services to all our patients by 2015, we need to change the way we operate because we are currently not able to deliver the quality of care that everyone should receive.

It is our call handlers who hear the distress and anxiety that delays cause, as they hold 999 calls during busy periods when we do not have adequate staffing levels to meet demand.

Often, by the time an ambulance reaches a patient, they are frustrated and are less receptive to being referred to an appropriate place of care, and end up being taken to hospital.

The availability of our staff is, amongst other things, related to current annual leave and rest break arrangements, rosters which limit our ability to match 999 call demand, and the make-up of our frontline workforce. This means not every incident receives an ambulance in a clinically appropriate time frame and we have become over-reliant on overtime and contracted services to maintain safe levels of care.

To improve patient care, we need to make changes to how we use our staff. And many of the changes we are proposing have been adopted by other ambulance services.

Our commissioners are providing additional investment which will enable us to recruit more staff, but it is not just about having additional people, it is about how we ask those people to provide our services.

If we are asking our staff to work in different ways, then we need to ensure that they receive appropriate education and training, and that they have a career with the Service that meets their personal and professional aspirations.

Our staff are our key resource. For many, particularly frontline staff, joining the London Ambulance Service is about embarking on a career. And for this reason, a clinical career structure and appropriate training and supervision are essential.

It is understandable, therefore, that there is frustration amongst staff about the lack of progress with implementing a clinical career structure as exists in medicine or nursing. This has, in some cases, resulted in staff leaving to pursue other careers or work for other ambulance services where clinical leadership opportunities exist. Additionally, the lack of education and meaningful appraisals and feedback has led to a demoralised and underdeveloped workforce.

We are committed to delivering a clinical career structure as part of our modernisation programme. This will provide our crews with the opportunity

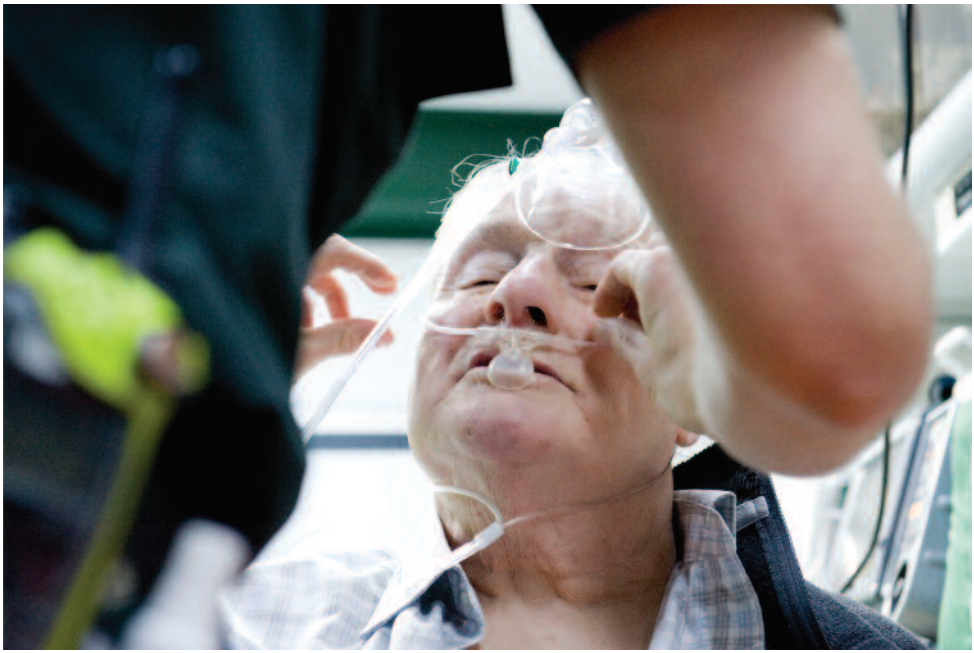
to progress to roles of clinical team leader, advanced paramedic and consultant paramedic – roles that provide clinical support and supervision remotely by telephone and on scene when needed. And we will improve education opportunities and supervision.

The additional education will ensure that paramedics are confident to work as autonomous healthcare practitioners and are recognised as such by other healthcare providers.

We have a leading clinical audit and research unit, and through their work we will continue to develop the clinical care we provide which will improve healthcare outcomes. This will include, but not be limited to, monitoring the quality of care and patient outcomes, with regular reports on stroke, cardiac arrest, heart attack and trauma, providing feedback on documentation and developing research within pre-hospital care. All our frontline staff will be encouraged and supported to undertake audit and research and play an active role in governance.

By 2015:

- On scene senior clinical support will be provided to staff where needed.
- Staff will benefit from an embedded clinical career structure, education and regular meaningful feedback and appraisals.



What will this mean for our patients in 2015?

In the future, every patient will be responded to in an appropriate time frame for their clinical condition by a registered paramedic who has received appropriate training in enhanced clinical assessment and has the right equipment to undertake their assessment. Paramedics will be supported by A&E support staff who have received additional training to work alongside them.

By ensuring a paramedic is on every ambulance we believe that outcomes will be improved and more appropriate referrals will be made.

There will be additional clinical support available at the scene as well as by telephone; this will also improve the quality of care we provide and patient outcomes.

We need to improve public understanding of how we manage 999 calls, and change the public's expectations of what service they will receive from us. We also need to move away from being seen as an emergency transport service to an organisation that provides an urgent assessment, health promotion and referral to appropriate services.

Every patient must receive the right care, at the right time, in the right place.

What will this mean for our staff in 2015?

Staff will benefit from an embedded clinical career structure, education and regular meaningful feedback and appraisals.

On scene senior clinical support will be provided to staff where needed.We will be less reliant on private and voluntary ambulance services as we will have recruited more staff.

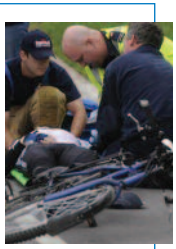
Further details of the changes to how we will educate and use our staff are given later in this document.

So what will be different in 2015 for Emily, the cyclist and Daniel?

Emily will:

- be responded to within an hour, whatever time of day
- be assessed by a paramedic supported by A&E support staff who will have received additional training
- be referred to her GP and a falls team who will be able to adjust her care so that she can stay in her own home
- have an improved outcome without having to be taken unnecessarily to hospital
- have no risk of infection or a prolonged stay in hospital
- be able to be assessed in her own home, and supported to stay there.

The cyclist will:



- receive an ambulance within 20 minutes
- be assessed by a paramedic supported by A&E support staff who will have received additional training, and possibly additional senior clinical support
- be given pain killers before being transferred to a local trauma unit.

Daniel will:

- have an enhanced telephone assessment within 30 minutes by a registered healthcare professional who can access relevant information from his special patient notes
- be referred for a mental health assessment by his community team without needing to go to hospital, if there is no medical problem
- be taken to the local hospital which has a co-located mental health liaison team, if there is a medical problem
- have his GP informed, with his permission.

Delivering care differently

As an organisation, we need to make a number of changes which will enable us to provide better care for our patients. It is anticipated that it will take up to two years to bring in all the changes and realise the benefits from them.

The change programme will involve:

- adapting our frontline workforce
- introducing a clinical career structure
- providing more telephone clinical assessments for less serious calls
- aligning rosters with demand
- providing rest breaks
- changing annual leave arrangements
- increasing vehicle availability
- extending the use of active area cover
- responding differently to patients

Adapting our frontline workforce

We are moving towards having more care overseen by registered paramedics, bringing us in line with other healthcare professions where registered professionals, such as GPs, registered nurses and therapists, always oversee and take responsibility for care. This also supports recommendations within the recently-published Francis report into Mid Staffordshire NHS Foundation Trust.

Our qualified staff have the freedom to make decisions based on a patient's individual needs rather than prescribed protocol. In the future, we will have a model which makes best use of the additional knowledge and skills that registered paramedics bring to patient care, ensuring more patients get the right care, first time.

To achieve this, we will need to crew paramedics and A&E support staff who have received additional training together on emergency ambulances, and, in time, all our single responders will be paramedics.

As well as ensuring that a paramedic will supervise every patient who needs an ambulance response, this way of working will increase ambulance cover locally, reducing patient waiting times. These changes will also enable us to

work more efficiently because we will be able to safely reduce the number of resources we send to calls.

Existing A&E support staff will receive additional training, so that they can attend a wider range of emergency calls alongside paramedics, providing greater job satisfaction. They will be able to provide cover across the full range of shifts, making them a more integral part of the Service.

Crewing paramedics with appropriately trained A&E support staff is now a nationally accepted model of care, which has already been adopted by most other ambulance services. We will increase paramedic numbers to be able to work this way.

We have not recruited to the emergency medical technician role for some years. There are opportunities available for technicians who want to train to become a paramedic. Alternatively, if they work on the frontline, they will be able to continue working within their existing scope of practice.

What does this mean?

- We are receiving extra funding this year to increase frontline staff numbers.
- In the future our emergency ambulances will be staffed by a paramedic with a member of A&E support staff with additional training, or an emergency medical technician or an apprentice paramedic.
- A&E support staff will be given additional training to fulfil this role. They will develop their skills in emergency care including dealing with trauma-related injuries, treating wounds and fractures and looking after patients with possible spinal injuries.
- In the future, only paramedics will respond in cars, on motorbikes and on bicycles. Changing to the new workforce model will take time, however, and until paramedic numbers have increased emergency medical technicians will continue to work as single responders.
- These changes will require some staff to move from their current place of work and everyone could have to work with different colleagues.

Introducing a clinical career structure

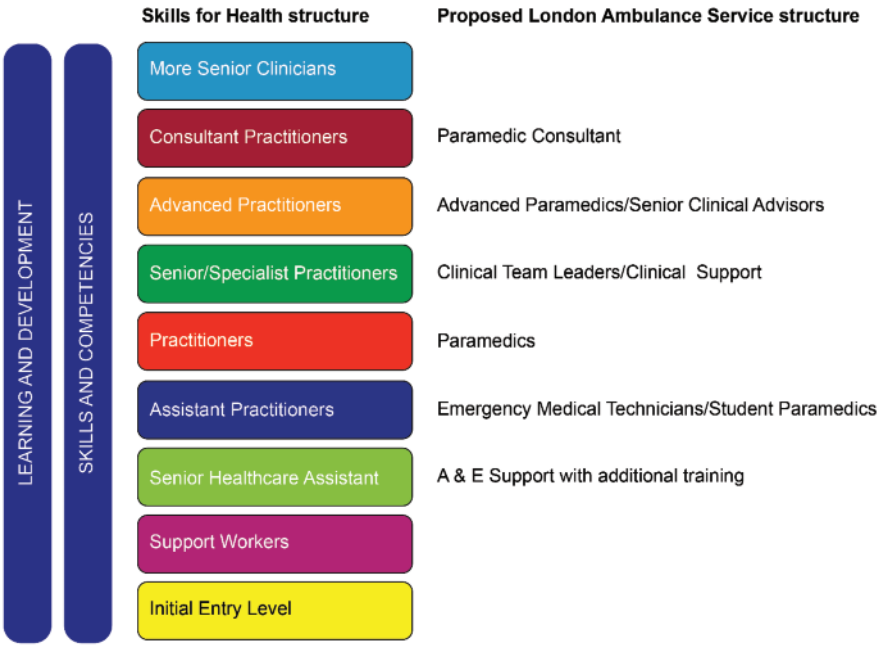
We are committed to introducing a clear clinical career structure so that our frontline staff are able to develop their clinical skills and progress their career within our Service.

Providing a range of career options will also enable us to respond better to emerging patient needs and changes in local health service provision. Our clinical career structure will support the recommendation from the Francis report for organisations to provide a leadership framework that puts patient safety, accreditation, development, common standards of competence and compliance at its heart.

Our starting point is illustrated by the diagram below which shows a range of potential ambulance roles aligned with the national clinical career structure developed by the sector skills council for health, Skills for Health.

We will work with clinical staff across the organisation to identify the best way to bring in this proposed structure.

Suggested clinical career structure



Providing more telephone clinical assessments for less serious calls

Many of the 999 calls we receive are to patients who do not have life-threatening injuries and illnesses, and who do not need an ambulance crew to attend. Instead they can be given a full clinical assessment over the phone and safely be offered advice, or redirected to other healthcare providers.

This means they get the right care first time around without unnecessary trips to hospital, and patients with more serious conditions who need an ambulance response will get care more quickly.

We have secured funding to increase staffing levels in our clinical hub – which includes the clinical support desk and clinical telephone advice teams – so that we can provide an enhanced assessment over the phone for more patients who are categorised with less serious conditions.

Staff in the clinical hub will review patients where the call is categorised as C3 and C4 and will continue to provide additional clinical oversight for other categories of calls.

To reduce waiting times for these patients, we have worked with our commissioners to agree more clinically-appropriate response times for patients dealt with by the clinical hub who are identified as needing a face-to-face assessment.

What does this mean?

- We will increase staffing levels within the clinical hub – which includes the clinical support desk and clinical telephone advice teams.
- There will be a separate consultation for staff who work in the clinical telephone advice team, starting in May 2013, about the planned changes to how we offer telephone advice in the future.

Aligning rosters with demand

Changes in demand mean that current rosters no longer provide us with sufficient frontline staff at the times that our patients really need us, particularly in the evening and at weekends.

We have hundreds of different rosters across the Service, many of which are not flexible enough to provide cover when it is needed.

Working with staff and a specialist company, we will be introducing a roster system that will align shifts with demand so that patients get a good service, no matter where they are across London and what time of the day they call us. There will need to be a greater mix of shift lengths to achieve this, though there are no plans to move to a full eight-hour shift pattern.

Importantly, training time will be protected in the future. Staff will be given an 'individual learning account', through which they will be able to book themselves on to core skills refresher training.

The new rosters will be designed with staff by the end of November 2013, and will be fully implemented by the end of March 2014, once we have recruited enough staff to cover them.

As staffing numbers increase, we will become less reliant on using private ambulance services.

What does this mean?

- We will use the detailed information about demand, obtained through a recent independent review, to identify the cover needed at each station. And working with staff and a specialist company, we will develop rosters that provide this cover using the existing jointly-agreed framework.
- Working arrangements for current relief staff will be reviewed and improved to ensure fairer distribution of work and more flexibility for this group of staff.
- These changes will require some staff to move from their current place of work and everone could have to work with different colleagues.

Providing rest breaks

Frontline staff tell us that very few of them receive a break during their busy shifts. And the existing arrangements, which restrict breaks to ambulance stations, mean that many staff who are allocated a break have it cancelled because they receive another call on the way back to their station.

Currently, staff are allowed to finish before the end of their rostered shift if they are not given a break. This means that during shift change over periods (6am to 7am and 6pm to 7pm) we don't have enough staff available to respond to calls and many patients have to wait too long for our help.

We plan to introduce new rest break arrangements by the end of June 2013. By early 2014, once we have increased staffing levels and new rosters are in place, we expect to see many more frontline staff benefiting from the break they are entitled to. This will help to ease the pressure on staff.

Importantly, the new arrangements will mean we will be able to give our patients a good service, whatever time of day it is.

What does this mean?

- Someone working a shift between six and 10 hours long will get a 30 minute break; the first 20 minutes are unpaid and uninterruptible, and the final 10 minutes are paid time and may be interrupted for the most serious calls (Red 1) where no other resource is available. Someone working a shift of 10 hours or more gets a 45-minute break. The first 30 minutes of the break is unpaid and uninterruptible; the final 15 minutes of the break is paid time and may be interrupted for Red 1 calls where no other resource is available.
- The decision to stand staff down for breaks lies with control room staff and existing software will be used to allocate the breaks.
- Rest breaks will be allocated at the location the crew becomes green and available, and within a specific window of time.
- Once on a break, staff can spend the time in whatever way they wish, and wherever they wish, provided that they are ready and available for work at the end of the unpaid period.
- In the event that no rest break is given, staff will be entitled to compensatory time for the unpaid element of their shift (20 or 30 minutes), and this should be taken within 13 weeks.
- No compensatory payments will be made.

Changing annual leave arrangements

Our annual leave arrangements for frontline staff do not give us the flexibility we require to meet demand and often leave us with insufficient cover to provide the level of service patients need from us, particularly at weekends.

Up to 15 per cent of staff at a complex are granted leave based solely on total staff numbers that should be employed at that complex. However, this does not take account of roster patterns, vacancies, or staff who are already absent through sickness, maternity leave, training etc, meaning absence levels are often much higher than they should be. Sometimes they are as high as 50 or 60 per cent, which impacts on patient care and puts additional pressure on those staff who are working.

We will introduce a system that provides us with cover when it is most needed whilst enabling staff to take their full leave allocation during the year.

Staff will find it easier to manage their leave entitlement and will have the opportunity to take all their leave, and managers will be encouraging them to do so. The amount of leave that staff carry over into their next leave year will be brought into line with support directorates and will reflect the arrangements across the wider NHS. The maximum amount of time that can be carried over will be, in exceptional circumstances, up to 37.5 hours.

What does this mean?

- A new web-based system will make it easier for staff to request and keep track of their annual leave using a secure login.
- A minimum of two weeks' notice will be expected. Requests made with less than two weeks' notice will only be considered by the on-duty management team; the resource centre will not be able to grant these requests.
- Annual leave will be allocated based on a percentage of hours produced by staff to cover all ambulance complex rosters for each day. To ensure the even spread of leave across shifts, this will be allocated by all shifts across the complex for the day.
- Any compensatory time that is accrued in lieu of rest breaks will be deducted from any request for annual leave. If a member of staff's time in lieu does not cover the shift, annual leave will be used to make up the shortfall.
- The resource centre will action leave requests within 24 hours of receipt.

Increasing vehicle availability

By having more vehicles available, we can offer a better service to patients. We need to ensure that our vehicles are more readily available and better prepared for frontline staff 24/7.

Compared to other ambulance services covering urban areas, we have high 'vehicle off road' rates. We plan to increase vehicle availability by reducing overall downtime (the number of hours that are lost because vehicles are off the road for repair, restocking, cleaning, missing equipment and staff welfare) by 0.5 per cent to 5.1 per cent by the end of June 2013. We will continue to reduce downtime each year so that by March 2018 we achieve a maximum of four per cent.

To improve levels of service to operational staff, we are setting up a dedicated unit at Bow that will be a single point of contact for managing all vehicle availability and controlling vehicle downtime.

We will be progressively reducing the age of the fleet over the next five years, which will give staff better, more reliable vehicles, and we will improve the management of our fleet. By May 2013, fleet technicians will be providing mobile workshop coverage across London 24 hours a day.

What does this mean?

- The central support unit and vehicle resource centre will work together at a new production hub to provide a single point of contact for all 'vehicle off road' matters and offer a consistent, 24-hour approach to managing the availability of vehicles.
- We started to introduce new workshop rosters in April 2013, including more unsocial hours, so that vehicles can be serviced on time, increasing reliability and reducing the risk of breakdowns.
- Mobile workshops will increasingly be used to repair vehicles away from workshop sites.
- The 'Vehicle off road' procedure (OP44) will be revised and published in May 2013 giving more general guidance on what is expected from staff and managers regarding 'vehicle off road' matters.
- Vehicle preparation teams will allocate vehicles overnight so that staff are given the most suitable vehicle for their shift.
- We will reduce the maximum age of ambulances to seven years and cars to five years, and we will implement a robust fleet replacement programme.

Extending the use of active area cover

Under the active area cover policy, staff working on ambulances, cars and motorcycles are placed in demand hotspots where the next emergency calls are highly likely to come from. This is to help reduce the length of time patients wait for a response from us. It also means staff are in the right place at the right time, and are less likely to get cancelled on the way to an incident.

We have reduced the number of cover areas, which makes it easier to manage within the control rooms. And we are continuing to use locations which enable staff to provide roaming cover in an area rather than being situated at a fixed point.

By the end of June 2013, we plan to extend the hours during which we provide active area cover. By doing so, we will ensure patients continue to be at the centre of everything we do – placing staff out in the communities they are serving. Patients will get a quicker response because staff are closer to incidents.

What does this mean?

- The active area cover period will be extended to between 6am and midnight from June this year. We will move to 24-hour cover from 1 April 2014.
- Crews will be given a location by control room staff and will be able to roam within a specific area around that location.
- Staff may use local facilities at their discretion but must remain contactable at all times.
- Crews will not be tasked to provide active area cover in the first 30 minutes of their shift. Staff not on calls will, wherever possible, be returned to station 30 minutes before the end of their shift, but remain available to attend incidents.

Responding differently to patients

Historically, we have sent a single responder as well as an ambulance crew to many calls in a bid to achieve our response time targets. This is not the best way to use our resources, it doesn't necessarily benefit our patients and it means that staff are regularly cancelled while they are on their way to a call.

We therefore plan to reduce the number of resources we send to individual incidents. We estimate that by responding differently to different categories of calls, we can reduce vehicle activations by over 400 a day, which will benefit other patients who are waiting for our help and will reduce cancellations for frontline staff.

Our proposals reflect how other ambulance services work. However, we will not bring in these changes until we have adapted our frontline workforce, as we need to ensure the staff we send to patients can deal with any clinical situation. We are therefore planning to introduce this new response model towards the end of March 2014.

What does this mean?

- We will continue to send a minimum of an ambulance crew and a single clinician in a car, on a motorbike or a bicycle to our most serious calls. Referred to as Red 1 calls, these are patients in cardiac arrest or who are unconscious and have ineffective breathing. There are around 40 of these calls a day across London.
- In future, we will no longer automatically send two resources to Red 2 calls. These patients, who include people with diabetic emergencies and seizures, need immediate on-scene care and, in many cases, hospital treatment. They will therefore be sent an ambulance crew if this is the nearest resource, without a single responder backing them up. If, however, a single responder is nearer, they will be sent, followed automatically by an ambulance crew.
- An ambulance crew will be sent to Category C1 and C2 patients if they can reach these patients within the clinically-agreed target times. If not, a single responder will be sent, backed up by an ambulance crew only if, on assessment, the patient needs to go to hospital.
- Lower category calls will be assessed by a clinician in the control room, with an ambulance crew sent only if a patient needs to be taken to hospital.

What happens next?

Tell us what you think

These changes provide a real opportunity for us to improve our service to patients as well as improve the working lives of our staff, and we would like your views on them.

More detail about the proposals can be found on the intranet – *the pulse*.

You have until Friday 24 May to let us know what you think, and you can share your thoughts in a number of ways.

Complete the feedback form
You can complete and return the feedback form opposite.

Visit *the pulse*
You can fill out a feedback form on the intranet, *the pulse*.

Email
You can email your feedback to modernisation@londonambulance.nhs.uk

Join us at a roadshow
You can join us at a roadshow where you will be able to speak to us in person about the proposals.

Monday 29 April	10am – 1pm	Charlton Athletic Football Club The Valley, Floyd Rd, SE7 8BL
Wednesday 1 May	10am – 1pm	Marriott Hotel, London Heathrow Bath Road, Hayes, UB3 5AN
	3pm – 6pm	Marriott Hotel, Waltham Abbey Old Shire Lane, Waltham Abbey, Essex, EN9 3LX
Thursday 2 May	10am – 1pm	West Ham Football Club Boleyn Ground, Green Street, E13 9AZ
	3pm – 6pm	Heathrow Renaissance Hotel, Bath Road, Hounslow TW6 2AQ
Friday 3 May	10am – 1pm	Oakleigh House 358 Bromley Common, Bromley, BR2 8HA

Speak with your local management team
You can speak with your local managers if you have any questions.

Our next steps

We will review the comments we receive and consider what changes we need to make to our plans. We will then share the outcome with you.

Have your say

Your views are important to us.
Please complete this form and send it back to us by Friday 24 May.

Q1: Is there anything else we need to consider to ensure the changes we are planning will improve patient care and the working lives of our staff?

Comments

Q2: Are there any other changes we could make which would further improve patient care and the working lives of our staff?

Comments

Please return this form to:
Charley Goddard, HR Manager – Employee Relations
HR Department, London Ambulance Service, 220 Waterloo Road, London, SE1 8SD

London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD