London Ambulance Service
NHS Trust

New Ways of Working

Transforming Clinical Leadership

The objective is a simple one: to create on each ambulance station the perfect environment for clinical leadership to grow and flourish, improving not only the patient's experience, but also the job satisfaction of all the staff.

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Produced by Bill O'Neill
Assistant Director of Organisation Development

Contents

New Ways of Working

Transforming Clinical Leadership

Every once in a while, an opportunity arises to make a real and lasting change. This is not the type of change that happens when you give your home a fresh lick of paint, or move the same old furniture round to different positions. Just every so often, the time is right for deep, fundamental change; the kind of lasting change that makes a real difference to us and our working lives.

For me, the New Ways of Working is this kind of opportunity. The chance to create 'new' stations, where excellent patient care and staff development and support are the two top priorities. It is an opportunity to ask ourselves why we're here, what our purpose is, and how best can we organise ourselves so that each one of us contributes to fulfilling that purpose.

Change can be exciting, and it can also be daunting. It involves moving away from the familiar into sometimes unknown territory. But if we move forward together to meet this challenge in a spirit of partnership, shared responsibility, mutual trust and support, we will be able to make a real difference in improving not only the experience of our patients, but also each of our working lives.

This is a very exciting development in the history of the Service and I am totally committed to making it a success. This is our chance for that deep and lasting change, and I will be giving it my personal support every step of the way. I and the senior management team look forward to working alongside you all in making this vision a reality.

Peter Bradley CBE
Chief Executive Officer


AMBULANCE SERVICE
LONDON

New Ways of Working:

Transforming Clinical Leadership

1

The objective is a simple one: to create on each station the perfect environment for clinical leadership to grow and flourish, improving not only the patient's experience, but also the job satisfaction of all the staff.

With this visionary future firmly in mind, the Service has set about carrying out the work that will enable this vision to be realised. Our Service Improvement Programme – SIP 2012 is about creating a Service that responds appropriately to **all** our patients" and New Ways of Working (NWoW) is a crucial part of that. NWoW projects are the key elements of the Operational Model and Organisation Development and People programmes. There are also areas that overlap with the Corporate Processes and Access programmes. However, there is a sense in which this work has a very clear identity of its own, focusing attention on life on our stations and how that can be improved to the benefit of the organisation, our staff, patients, partners and the wider community as a whole.

The following areas have been identified as of key importance in establishing this new way of working on stations:

Staff Engagement

Staff engagement and communication are often spoken about separately but they are part of the same thing – you cannot have one without the other. For simplicity, this work refers to these two activities as staff engagement.

Healthy staff engagement is at the core of positive culture change and is absolutely key to the Service's future success.

In the organisation of the future, in the 'new' station complexes, it is vital to create a culture of engagement, where staff feel they are kept better informed and involved. It must become the way the Service does business.

Future Clinical Response

This is about the way that the Service deploys its vehicles and clinical resources in response to operational requirements. The Operational Model projects – supported by other related projects - will contribute to the delivery of better patient care by:

- Enabling us to get to patients sooner (two minutes sooner)
- Providing access to resources and pathways most appropriate to the patient's need
- Delivering a sustainable, consistent service across London, capable of absorbing variations in demand and giving equality of access.

The projects are about putting in place changes to the way clinical response happens through:

- Sending to each call the staff most appropriately trained to deal with that call
- Increasing the use of cars to better enable the most appropriately trained staff to reach patients more quickly, more of the time
- Increasing access to alternative care routes for patients, allowing them to be cared for in the way most appropriate to their needs, saving fully equipped ambulances for those calls that genuinely need them
- Providing staff with the appropriate levels of training and development to deliver the above.

The Education & Training Plan

The Education & Training Plan recognises the aspirations and strategic direction of the organisation to deliver more post-registration continuing professional development and training at station level whilst maintaining a programme of recruitment and pre-registration courses at our training centres and providing a workforce that is skilled appropriately to satisfy the aspirations of the workforce plan.

(The full plan can be found on *the pulse*)

Modernising the Delivery of Training and Development

The Service, in common with much of the NHS, is now beginning to move toward a model of delivery for education and training that not only relies on working relationships with HE partners but that places much greater emphasis on the provision of workplace-based, practice learning that allows experiential learning to sit alongside theory-based learning as equal partners, and uses the expertise of practitioners to assist staff in developing their practice. In addition, the provision of online learning will further enhance the access to development and training for all staff.

Clinical Leadership and Support

Continuing improvement in clinical leadership within the Service will be achieved through providing not only higher level leadership and commitment, but also through appropriate and reliable resources, development, information, guidance and performance appraisal and feedback being made available to station-based clinical and training leads, who will actually deliver the clinical leadership agenda.

The Service's patient care agenda will be clearly stated and able to be easily understood by all clinical staff. It will be kept focused, involving a small number of key objectives that are well communicated, initially from the Medical Directorate and senior management team.

Although there is clear recognition that the clinical leadership roles fall largely to the station complex's management team, all operational staff will accept that clinical leadership is part of everyone's role, and take responsibility for their own clinical practice and development.

The Clinical Audit and Research Unit (CARU) is the part of the Medical Directorate that undertakes robust scientific research projects to explore new avenues for treatments and services aimed at delivering the best possible care to our patients. Additionally, through its programme of systematic clinical audit, CARU monitors and reviews the quality of the care that is delivered to our patients and recommends appropriate changes to practice aimed at improving patient care both locally and at a national level.

In establishing enhanced clinical leadership on stations, the interface between frontline managers and staff and CARU will itself be enhanced, and will allow our clinical care to be better monitored and evaluated, and information and feedback made more readily available to help inform individual practitioners' appraisal and development, and thereby their practice.

Complex-based Roles & Responsibilities

As part of this work, redefinition of the roles that enable clinical leadership to exist on complexes will provide clarity of purpose, identify interdependencies and reliance between roles, and enable critical success factors for each role to be established and monitored.

Clinical Workforce Reconfiguration

Detailed work has been undertaken to identify the likely front-line clinical workforce requirements, based on modelling and planning assumptions made for the plan period 2007-2013, to best enable the delivery of the improvements to responding to patients detailed previously.

Analysis has shown that we will need larger numbers of staff with enhanced patient assessment skills working as single responders. Crew staff numbers are planned to increase over the period by around six per cent (eight per cent including the increase in CTA staff). There will be a four-tier frontline workforce: emergency care practitioners; registered paramedics, a reduced number of emergency medical technicians; and emergency care assistants (title under review). This will create a front-line clinical workforce with almost 80 per cent of staff providing direct care to patients being professionally trained, together with an increase in those with basic training. The majority of existing emergency medical technicians will be up-skilled through professional, higher education accredited training to paramedic status at diploma level, complemented by the recruitment of university trained paramedics.

The Restructure of Education & Development

The context within which ambulance services provide education and training for their staff is changing nationally. With greater emphasis on the merging of internally delivered training with higher education (HE)-based development, the workforce review and the emerging financial/funding pressures for all training outside medicine and nursing, there is a need for a fundamental shift in the way that ambulance services design, plan and deliver staff training and development.

For the Service this will mean that over the next five years:

- Greater emphasis will need to be placed on front-line staff's clinical development and continuing professional development than is currently the case
- There will need to be an enhanced internal capacity for upskilling EMTs, and developing existing EMTs to paramedic level (bearing in mind the anticipated increase in the academic standing of the paramedic award from certificate to diploma), and in upskilling existing paramedics to the new standards of education.

It is within this context that the changes proposed in this document are made. The objective of the changes is to meet the above stated challenges through:

- Increasing the number of training delivery positions
- Putting more of those posts onto stations
- Modernising our use of managerial positions
- Making greater clinical support and advice available to staff.

Working Practice Modernisation

There are a number of existing practices that will need to be modernised to allow new ways of working, teamwork and leadership to emerge and be developed, including:

- Review of working patterns (rosters) and

exploring concepts such as self-rostering, annualised hours and the creation of 'watch' systems to meet the joint goals of establishing genuinely flexible working arrangements, and the provision of dedicated training and development within rosters

- The establishment of real teams, enabling good, reliable face-to-face communication to take place, consistent and reliable management and leadership, and the development of strong relationships between team members

- Dynamic deployment of vehicles where staff accept they will be mobile for most of their shift, returning to their base only for their rest break

- Revisiting the rest break agreement

- Reviewing annual leave arrangements in light of whichever team working pattern system is chosen.

Organisation Development & Leadership

As part of the Organisation Development strand of the New Ways of Working, three distinct areas will be developed:

Performance Management

Within the Service's New Ways of Working, performance management will be established as a positive, comprehensive system through which good individual performance and the achievement of personal, business and development objectives are identified, recognised and rewarded, and through which below standard performance and non-achievement of objectives is fairly appraised and monitored, with appropriate support and development available, and clear and consistent performance capability processes are applied where necessary.

Talent Management

The organisation will put in place a framework of access to dedicated, targeted development for any member of staff from across all departments who has been recognised (or who recognise themselves) as having the raw talent for leadership. Through a process of initial selection and appraisal, the strengths and potential of these individuals is explored, and with their managers, a development plan is designed that enables them to work toward reaching that potential through promotion.

Leadership Development

Whilst a traditional 'managerial' or transactional 'command and control' approach is sometimes necessary, and is an important part of any leader's toolkit, it will no longer be the default style for the Service, where empowering, inclusive transformational leadership will become the prevalent style.

We will approach the leadership of the organisation in the same way we approach patient care - that is, by engaging and communicating with individuals to better understand and meet their existing and emerging needs, and by motivating and inspiring them to develop both themselves and the organisation to enable continual growth, effectiveness and success. In addition, the senior management team will clearly act as role models, providing example of transformational, values-based leadership in action.

Information & Technology Systems Support

As a vital enabler of the New Ways of Working, IM&T's Access Programme will support clinical leadership on stations through:

- Electronic PRFs being fully installed in all response vehicles

- Many training modules, both clinical and non-clinical, being delivered by web-based e-learning packages

- Every crew member carrying a digital radio that

provides point to point communication for crew members, direct access to the control room and a panic button in case of emergencies

- ESR being the single repository for all staff data, including records of personal issue equipment. Application forms are all electronic and from the moment of initial enquiry, the entire employee process is automated

- All staff booking on/off duty (ultimately using swipe cards), so time recording will therefore automatically satisfy the requirements of the Working Time Directive

- All managers who have a justified business requirements having a laptop computer equipped with full remote access, allowing 24/7 access to all corporate services. All staff will have access to basic e-mail (known as web mail) from any internet terminal – essentially giving free access to Service e-mail from home computers or internet cafés

- The concept of 'IM&T Super User' being established. This role is a recognised responsibility undertaken by appropriate staff at each main Service location. The person provides local user support and has a direct liaison with the IM&T Customer Services Department, who provide ongoing support and training

- There being a 24/7 IM&T Support desk that acts as a single focal point for all IM&T support

- There being a new, fully integrated CAD system supporting two control rooms (each with 100 per cent spare capacity for resilience). Reliability is 99.9 per cent plus with complete system failures now unheard of

- Access to information being provided by a suite of reporting tools that reside on all desktop and remote access computers. There are different levels of tools, and staff are able to generate reports as and when they require them, according to their access rights

- Providing a new suite of services for people who do not speak English, and/or who cannot use the telephone as an able bodied person would.

Operational Support

Operational Support is being transformed by a number of initiatives and corporate projects to support the New Ways of Working.

Fleet, Logistics, and Make Ready are gradually being integrated into a single command unit to improve co-ordination and achieve maximum synergy.

There is a comprehensive review of Fleet Support Services being undertaken which is considering the future sizes and numbers of workshops, staff levels, hours of work, and additional services. Larger workshops, increased hours of work, additional mobile workshops, and a 24/7 call centre are being planned. Ensuring that vehicle resourcing is managed and maintained will be a key task.

Logistical support will be delivered centrally by an integrated Tender/Equipment Support Personnel Service operating from the Logistics Support Unit. The merged operation will cover all services such as drug pack exchange, equipment exchange, blanket exchange, and post collection/delivery.

Medical consumables will also be managed centrally and local stores maintained to minimum/maximum levels by Logistics staff.

The Logistics Support Unit will operate a 24/7 service. Electronic asset tracking and inventory control projects will be implemented to improve oversight and make efficient use of resources.

The local Operational Support Centre will contain a Fleet Workshop, Logistics Co-ordinator, and will be home to a Make Ready staff member. Vehicles will be deep cleaned when they come in for servicing. Daily cleaning and equipping will be carried out by mobile services. Spare vehicles will be held at these centres.

Partnerships within Health and Social Care

As a result of the New Ways of Working, ambulance staff will have a much bigger range of options for their patients and much more training to support good decisions about which to choose. They will be able to arrive at their patients knowing that they are better able to provide what they actually need.

If a patient does need to travel, staff will be able to take them to minor injuries units and walk-in-centres, urgent care centres and polyclinics instead of the emergency department. They will also be able to refer them to district nurses, psychiatric crisis teams, falls teams and intermediate care – schemes designed to support patients in remaining independent in their own homes.

Ambulance staff will be much more familiar with how these services work, often because the professionals running these services have provided training and familiarisation.

As clinical leaders, team leaders, trainers and ECPs will be able to provide support and advice in the decision-making required. The ambulance operations manager will be a regular member of the PCT's urgent care network and it is part of his/her role to seek out new opportunities for co-operation with other parts of the health and social care system.

Community Engagement

On each ambulance station complex there will be a Community Involvement Officer designated to lead on Patient and Public Involvement (PPI), public education and building relationships with partners in their area.

PPI and public education will be regarded as 'core business'. There will be a budget, held on the station complex, allocated specifically to meet the costs of community engagement work. The community involvement officer will report to the AOM and his or her performance is monitored against clear objectives and a Personal Development Plan.

The community involvement officer will identify other people on their stations who (a) already enjoy doing PPI and public education work, and have the skills to do it well and (b) those who would like to get involved, or for whom it would be a good development, but whose skills and knowledge need to be improved. In this way, no-one who is interested in this work is excluded. All of the people so identified can then have PPI and public education work in their Personal Development Plans and personal objectives, and will be supported to develop and to participate in this work.

Benefits

In summary, the point of the New Ways of Working is to realise the following benefits:

- To resolve patients' needs without them having to leave home
- To take fewer patients to hospital
- To achieve better survival rates for patients who are seriously ill and injured, especially those suffering from:
  - Myocardial infarction
  - Cardiac arrest
  - Stroke
  - Serious trauma
  - Respiratory arrest
- To achieve even better patient satisfaction
- To achieve high levels of staff satisfaction
- To achieve organisational improvement.

The Station Vision –

New Ways of Working

"My name is Johnny O'Keefe, and I'm a Team Leader.
I've been in the Service about 12 years.

Two years ago, in 2008, the Service began to introduce the, New Ways of Working' at ambulance stations (or 'Extreme Makeover – LAS Edition' as I call it!). As part of the process for deciding which stations to start with, complexes were asked to present their bid for being the first. My station was one of the first three stations chosen. From then on our complex, and the community it serves, was given all the help it needed to make the new ways actually work!

So, what's it like to work here now? Probably the best way to show you is by describing a typical working day – here's how yesterday went!

I arrived on station and swiped my I.D card to book myself on duty. It seems a long time since I used to have to 'sign on and off' duty! As I swipe my card, EOC recognise that the vehicle is going to be staffed and know my level of training.

There was an e-mail from my AOM in my inbox about my application to join the Talent Management Programme. Great news! I have an interview next Tuesday!

I took a 'handover' from the team leader of the watch going off duty at 7am; they had a busy night again. At 6.30 the rest of our watch arrived and 'swipe in'. Once they had a cup of tea in hand I started the daily briefing. Yesterday we were covering all the early vehicles: two 12-hour ambulances, one 10-hour ambulance, two 12-hour cars and two 12-hour UOC/Central services vehicles. The cars and A&E ambulances almost all have a paramedic on board now, supported by some emergency medical technicians and emergency care assistants.

First on the agenda was the rota for next month. This used to be sorted out by the Resource Centres, but we found we could get better cover, reduce sickness and keep people happier (and healthier!) if we did our own resourcing. Now the team have a free hand to cover the shifts however they choose, so long as they're covered! We've seen everything from split shifts to permanent Friday nights in our ever-changing rota! The team love the flexibility and there always seems to be someone who will cover your duty if you have a DIY job to finish off, or the child minder goes sick! This flexibility has created a real 'team' feel where everyone looks after each other. Sickness has plummeted, or as one team member put it, "We don't do sick in this team!"

The team was one person 'over strength' yesterday; Jon, one of the team's reliefs, hasn't been needed much this month and so needs to use some hours to meet his quota. This gave us the capacity to use the day to develop one of the team. Erina, one of the team's paramedics, is hoping to apply for team leader soon, so this was a good opportunity for her to meet one of her PDP objectives by refreshing her maternity skills, in advance of the exam paper. A quick call to my contact, Jill, in the maternity department and Erina was soon on her way for a day of screaming babies!

I briefed the team on the main points from the latest RIB and CARU bulletin – they can catch up on the detail at their leisure. As usual they asked some

sensible questions which I fed 'up the line' to the trainers. Should have some answers for them today.

Finally, we discussed team performance and our position in relation to the other teams. As usual we are top on Cat A, but what the team really want to improve is our cardiac arrest survival figures (we're behind Tom and Liz's watch who have a brilliant 37% survival!), so that will be the focus for the next month.

At the end of the meeting we agreed who would be covering each of the deployment points. These are prioritised from one to four depending on how busy they are. Whatever happens, we always try to keep number one and two covered with an ambulance and a car. Everyone moves up a point when the other vehicles are sent on a call. This means that we are normally in the best place for the next call coming in. We also all move round at lunch time to share out the workload across the day.

Our first call of the day was to a patient with COPD. On the way, (whilst Jo drove) I brought up the clinical guideline for COPD on the MDT and had a quick read. I noticed there was a recent CARU bulletin attached and I opened that too. This reminded me of the need to score the patient's pain. No problem!

After thoroughly assessing and treating the patient, I arranged for him to be taken to the hospital where he is known, and called for my Urgent Care ambulance to get him there within an hours. Back in the ambulance I quickly completed the electronic PRF and sent it off.

I was then asked to go and help out one of our crews who were attending a terminal cancer patient who had taken a turn for the worst – the crew weren't sure what to do for the best interests of the patient whilst taking into account the distress of the relatives. I went along and together we came up with a plan that helped address the concerns of all involved and arranged for the palliative care nurse to attend, allowing the patient to stay at home in relative comfort.

After a busy morning we went back to station for a break, at a time that had been agreed with the rest of the team that morning to maintain cover.

It was a bit quieter after our break and the final call of the day was to an RTA. It was quite serious and we decide to bypass the A&E, to go to the trauma unit. It all went smoothly and we were able to turn round quickly now that we don't have to book patients in.

Back on station I had the usual 'wash up' meeting with the team. It was a good day. I thanked the team and they all went home for a well-earned evening. I held a performance review meeting with one of the team though, as I wanted to recognise his extraordinary ability to get more letters of thanks, over the past six months, than anyone else. Must be something there that the rest of the team can learn!

It's also probably worth describing what difference the new logistics arrangement for equipment and vehicles (apparently it's now called 'operational support'!) has made to us on station.

Since the introduction of the New Ways of Working, the delivery of operational support has been transformed. The Fleet Engineering, Logistics, and Make Ready services are now fully co-ordinated under one command.

Let me give some examples of this. This morning the equipment support personnel (ESP) will call. There used to be two operatives who would call at different times to deliver logistical support. Now one person calls within an agreed time slot. They exchange drug packs, equipment and blankets, collect PRFs and deliver the post. They use electronic held devices to keep track of equipment and drug packs. A database is available to check where equipment is being held and when drug packs go out of date. There is no need to do time consuming paper audits any more!

The Logistics Support Unit is now open 24 hours a day. If any additional help is required in the evenings and at weekends, you can ring one number and someone will deal promptly with your request. This really helps if we are short of blankets as more can be delivered by the Unit.

Medical consumables are now managed by Operational Support. The ESPs maintain the consumable stores using a minimum/maximum stock management system. There are no longer any shortages or items that go out of date and we don't have to spend time chasing up orders any more. We have a small running store that we use during the day to top up vehicles.

Fleet engineering services are now provided from large workshops working longer hours. There are mobile workshops that operate in the evenings and at weekends. The Fleet Resource Centre manages all issues around vehicle availability, servicing and repair. You just call one number at any time and the call centre will arrange for a mobile repair to be carried out, a tyre to be replaced, or a new windscreen to be fitted. Some broken down vehicles are also now towed into workshops rather than having to wait for the RAC!

When we start work each day a fully equipped, clean vehicle is waiting for us. We don't have to worry any more about finding spare or replacement vehicles. Spare resources have been pooled and are held centrally which means they are now available to anyone who needs one. The Fleet Resource Centre will send a replacement within one hour if a local repair cannot be carried out. Vehicles that need servicing are taken out each night and there are no longer any backlogs. "Ferry drivers" are employed to move vehicles between the station and workshops. We no longer have to waste valuable time waiting for and collecting vehicles.

Make Ready now operates from the large workshops. These workshops are now part of Operational Support Centres where a logistics co-ordinator manages equipment and vehicle cleaning services. Our vehicles are now deep cleaned when they are serviced at workshops. Vehicles are cleaned and equipped on stations by mobile resources. This helps Make Ready as they can clean vehicles at satellites or at hospitals.

The best thing I can say about operational support is that our concerns about vehicles, equipment, and consumables have gone away – they are no longer issues. All our time can be spent on providing good quality clinical care. Operational Support is proactively delivered and customer focussed.

That just about sums up what a 'normal' day on station looks like these days. But there's loads more stuff going on now outside the station than there used to be too!

Our team have adopted one of the local community centres for the year and have raised several thousand pounds from sponsored bike rides, marathons and other charity fund raising activities. This one is used mainly by Bangladeshi and Somali women. Some of the locals from another part of our borough have joined together with Service staff to form a cricket team that has entered a local league – they're doing OK too!!

Our local College of Further Education has begun two new and interesting courses. One is designed to improve community engagement, and is aimed at public sector staff, teaching them about the local community, its history, traditions and problems. Students meet key players in the borough, and work on a project with one of the community centres. Five staff from our complex attend this and say it's been really interesting and useful. The second course is aimed at local people, and was developed as an access programme for the Paramedic Science Foundation Degree course, now being run at a number of universities. At the last recruitment event the Service held in the borough we recruited 15 people, mostly from Bangladeshi background, and five were women.

The Service's Decontamination Team carried out a demonstration of their work at a local park. Judging from the photographs everyone had a

great time and loads of fun. The Decon Team got a ton of useful feedback on how to improve their procedures, particularly regarding those difficult language, cultural and religious obstacles.

Our station's Community Involvement guy Sam hosted a delegation of local residents and arranged for them to have a tour of EOC and a briefing from the Service's Olympics project team on how we are preparing for the 2012 Games. Sam is always getting local press coverage about the station and what we're doing; it's made a real difference.

Seeing as, at the end of the day, we're here to treat patients, the most brilliant change of all is that the health of the people of our borough has improved significantly over the past two years. Cardiac survival rates have come up to just short of the average for London, with significant gains for Bangladeshi men, who were previously well behind other groups. Infant mortality rates in the Borough have improved following implementation of the recommendations from the Service's Obstetrics Audit. The self-reported health assessment of residents has also risen to just below the average for London. Following our successful rollout of the diabetes management awareness sessions the number of diabetic-related calls to EOC has declined significantly. To show off these successes, our borough is now the destination of choice for VIP visitors and international delegations who all want to see how we've improved the health of significant numbers of people in one of the poorest and most deprived parts of the Capital.

We've often talked about becoming a "world class ambulance service", we can now see just what this means for patients as well as for staff."

2 Staff Engagement and Communication

Effective, open and honest communication through an active programme of meaningful staff engagement will be at the heart of a successful ambulance complex.

Through this engagement, a growing loyalty and commitment will be nurtured, resulting in a positive impact on patient care and performance.

A strong commitment to good communication and a determination to engage with staff, recognising that everyone on complex can and should be able on an equal basis to contribute to improving the Service, will be key qualities of local management teams.

For the complex management teams to successfully develop this vital culture of communication and engagement, they will be supported by their senior operational managers and the senior management group (SMG).

Each management team will have a clear communication and engagement plan. This will cover both how they are communicated with and how they will communicate and engage with all staff on complex.

Managers will have clear information from the "top" to share and discuss with their staff. The communication lines between senior and frontline management will be clear and effective.

Current tools which include conferences, bulletins, e-mail will be examined carefully to ensure they are used to the greatest effect. We will develop new tools, some of which will involve expanding our intranet and harnessing the power of the new media. Others may include the development of simple briefing sheets or building more extensive conference call and video conferencing facilities.

Face to face communication (accepted as the most effective form of communication anywhere and everywhere) will be developed further. To encourage engagement, we must ensure that local managers have an efficient two-way process through which they can feed back the views of their staff and their own views.

As well as providing information to local managers – and listening carefully to them – senior leaders will be aware of the need to build their visibility. The CEO staff consultation meetings will continue but further communications activities will be developed throughout the year for the Director of Operations, the senior operational team and other SMG members.

On complex, existing communication tools will be used to best effect. For example:

- Develop the local pages on the intranet
- Manage the noticeboard(s) carefully and constantly
- Make sure every member of staff has their own copy of bulletins.

These are small things but all play a role in the local manager's communications toolkit to be used to develop good staff engagement.

What else will be in this toolkit ?

- Regular complex management team meetings
- Regular management meetings with trade union representatives
- Regular complex/station meetings with frontline staff, involving staff in creating agendas and developing a resilient process of feedback and action
- Training events to support staff in developing clinical knowledge and skills
- Working groups – involving staff in local initiatives both internal and external
- Well conducted personal development reviews (PDRs). Results will be collated to identify themes.

Other activities should/could include:

- Local staff suggestion schemes
- Rewarding staff for jobs well done rather than just mentioning long delays or lengthy turn-round times
- Honestly feeding back to staff when their individual performance could be better
- Congratulating staff over letters of thanks
- Recognising service milestones – both through the formal corporate process and locally
- Developing social events.

Some of these are small things but they will all add up. They put credits in the credibility bank for when tougher decisions have to be made and uncomfortable actions taken.

The glue that will bind these more formal activities together to create a healthy communications culture is the day-to-day informal communications, with all staff feeling that there is equity of access to genuine two-way communication. This will involve the demonstration of excellent interpersonal skills through which all staff will feel noticed and that their contribution is recognised and valued.

The management team will consistently demonstrate the right attitudes and behaviours - a very powerful piece of communication in itself.

3 Future Clinical Response

The programme that relates to the new design and structure of clinical response and delivery – supported by other related projects - will contribute to the delivery of better patient care by:

- Enabling us to get to patients sooner (two minutes sooner by April 2008)
- providing access to resources and pathways most appropriate to the patient's need
- delivering a sustainable, consistent service across London better able to absorb variations in demand and giving equality of access.

The most serious (Category A) calls will be attended by a paramedic or an emergency care practitioner (ECP), within eight minutes of connecting the 999 call to the Emergency Operations Centre (EOC) in at least 75 per cent of cases, consistently across London. This will be achieved by sending an ambulance and a solo responder in a car as an initial response to the 20 per cent of emergency patients whose conditions are life-threatening and/or whose condition may rapidly deteriorate. We will also send a dual response to those calls involving a staff safety issue.

We will send a solo response to the remaining calls (about 70 per cent) which have not received telephone advice in the first instance. We will send an ambulance subsequently, only when a need is identified by the initial responder. To this end we will deploy either an Advanced Life Support (ALS) ambulance crewed by a paramedic and (in time) a revised EMT role, or a Basic Life Support (BLS) ambulance crewed by two emergency support staff (this is an end point and may need to be revisited in the future).

Cars and ambulances will be dynamically deployed off-station, there will be a raft of IM&T enhancements, and staffing will be 97 per cent against plan. There will be operational changes in Control Services, and a significant expansion in the number and use of local alternative care pathways.

Urgent calls will be dealt with predominantly through the Urgent Operations Centre. We will maximise the use of clinical telephone advice to ensure that patients receive the correct level of care for their condition, including home care advice and appropriate referral to other providers where necessary. The highest level of clinical supervision and assessment, including from team leaders, ECPs and in some cases GPs, will be available to ensure patient safety and satisfaction, both as an initial response to calls, as well as in response to referrals from other members of the Service's frontline staff.

Greater reliance will be placed on PTS and A&E Support staff in providing BLS ambulance responses. Where patients do require ambulance transport, we will ensure that the response they receive is appropriate to their condition.

By 2012 we will progressively reduce the number of patients taken to A&E. This reduction will amount to 200,000 patients per annum.

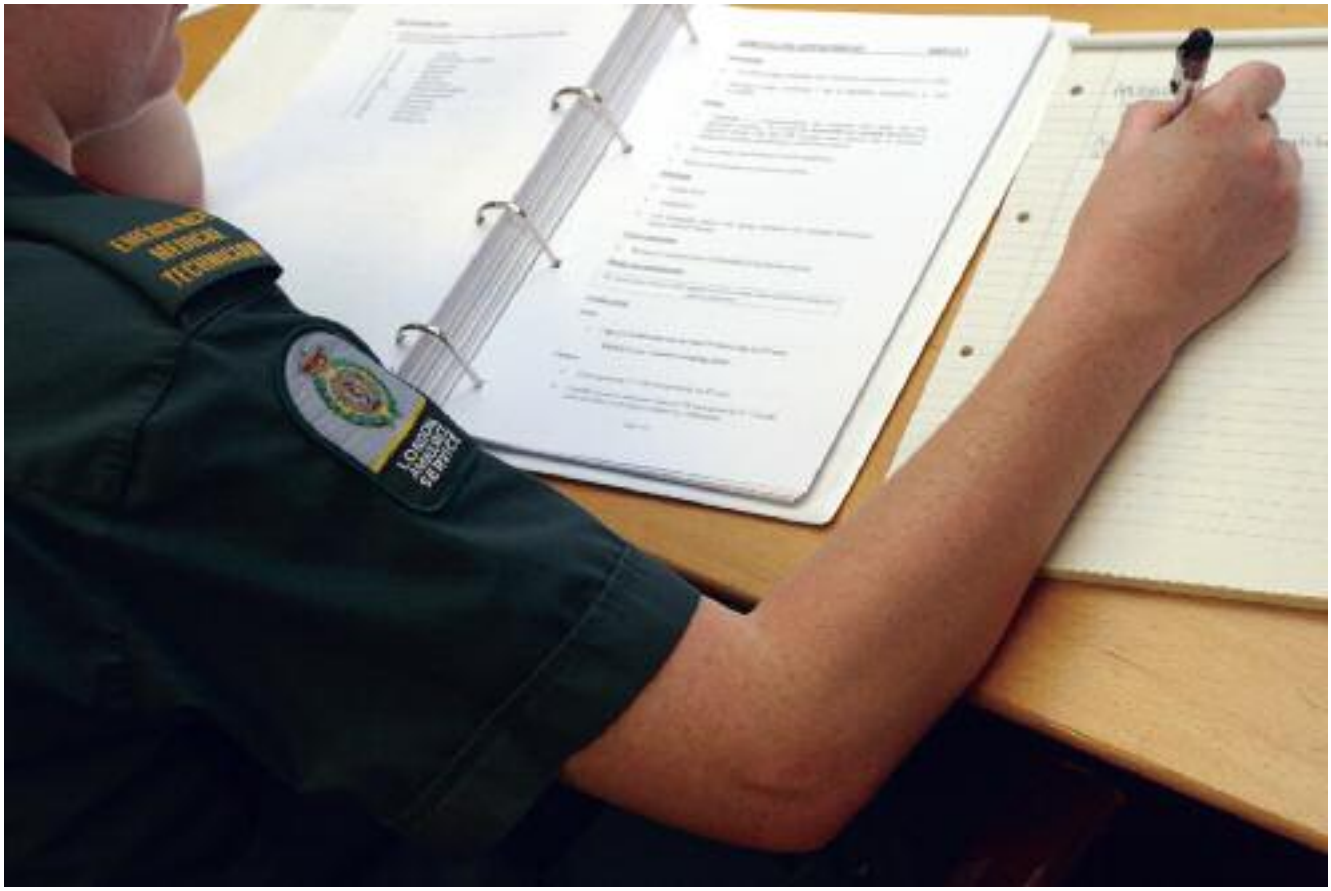
4 Modernising the Delivery of Training & Development

New Education & Training Delivery Model

The Service, in common with much of the NHS, is now beginning to move toward a model of delivery for education and training that not only relies on working relationships with HE partners but that places much greater emphasis on the provision of workplace-based, practice learning that allows experiential learning to sit alongside theory based learning as equal partners, and uses the expertise of practitioners to assist staff in developing their practice. In addition, the provision of online learning will further enhance the access to development and training for all staff.

Recruitment Courses

Recruitment training courses for roles other than paramedic will continue to be delivered at a Service Education Centre. The courses will be delivered by



appropriately qualified staff (for details of this see section 8 - Education & Development Restructure). Accredited by one or more of the Service's HE partners, each course delivered will be continuously reviewed and updated to ensure the highest standards are maintained, and quality assurance will be built into that process.

Continuing Professional Development

The Department of Clinical Education & Development will develop a schedule of available in-house courses/modules, accredited by one or more of the Service's HE partners, from which staff can choose and plan a development portfolio. In parallel the department will publish a list of approved externally-provided courses that staff can access. Whilst some modules will be compulsory (such as resuscitation training), there will be sufficient diversity within the schedule for staff to be able to choose modules that reflect their interests and/or development needs. These modules/courses will allow the Service to give staff access to only the highest standard of education and training.

CPD training and development will be delivered using this modular framework, delivered through a combination of:

- One/two-day classroom-based modules delivered by appropriately-qualified staff at either an Education Centre or on station (for details of this see Section 8 - Education & Development Restructure).
- Web-based e-learning packages
- Self-directed learning and reflective practice/mentoring
- Clinical placements to allow consolidation of theory and practical skills, facilitated by practice placement educators (see beow).

Some modules, such as manual handling, would clearly be suitable for all levels of staff to attend. However, where appropriate, modules will be designed to allow staff in particular grades, and with similar specific needs to attend together (e.g. all team leaders/paramedics would be required to access the advanced resuscitation module whereas all EMTs would access the basic resuscitation module).

Each classroom-based module will be one or two days in length (being either eight, 10 or 12 hour days), with some being half a day in length, properly utilising this time with both theoretical and practical content. In the first 18 months each person will be provided with three days' CPD. In future this will be replaced by the provision of protected training and development time within staff rotas.

Each member of staff will be required to agree with their line manager through the PDR process a minimum number of modules they would access over a given period of time i.e. 12 or 18 months. It will be the joint responsibility of both the complex management team and the individual to ensure this is completed. Monitoring of completion will be achieved through both regular one to one appraisal meetings between staff and supervisors, and the maintenance of a centrally administrated training database. Support will be offered to staff who are unable to meet the agreed objectives of their PDP, either through inability to reach the required standard, or through non-attendance or absence from work, as part of the Service's performance management framework.

Where the content of the module is web-based, each member of staff will be responsible for achieving the objectives for that module by managing their own study time in agreement with their line manager/supervisor. The local trainer will provide mentoring and guidance to enable the student to manage their own progress.

Each student will receive certification for each module successfully completed. This will allow a comprehensive training record to be established and provide evidence of development when staff are applying for promotion. Dedicated modules will

be developed for EMTs who are planning to undertake the paramedic course to ensure they are adequately prepared and thus maximising levels of successful completion.

All course/module content will be regularly reviewed by both Clinical Education and the Medical Directorate to ensure that subjects taught are up to date and still appropriate for the Service's needs. In particular, emphasis will be placed on the patient assessment aspect of all relevant courses to ensure it enables us to provide staff with the requisite skills to deliver the level of care that underpins the future operational response model.

Having the modular system will allow more access to development, more regularly, for more staff across the Service. For example a number of 12 lead ECG modules may run concurrently; one being for team leaders, one for EMTs, and one for paramedics.

Not all modules will require face to face teaching. The department will continue to move forward with e-learning which could allow the member of staff to access their development from both station and/or home, so long as evidence of completion can be demonstrated.

There are a number of technical subjects that will be included as modules. For example modules such as 'Road traffic collision scene management' and 'Introduction to complaint investigation' can be run to develop duty station officers. Likewise, a number of modules will cover or include subjects such as equality and diversity.

For this modular system of CPD delivery to be successful it is vital that each complex has clearly identifiable clinical leads, who will be the two dedicated trainers. It also requires a "buy in" from the AOM who must, as the clinical leader for each complex, and with the support of senior management, establish and support the development of staff as a priority issue for achieving excellence in patient care.

Paramedic Courses

Paramedic training and development will be consolidated at the Service's main education centre, currently at Fulham, which will become a 'satellite campus' for one of the Service's HE partners. This will allow the creation and maintenance of a core team of specialist training delivery staff (possibly lecturer practitioners jointly appointed by the Service and HE partner) who will deliver HE accredited education and development to diploma level. Additionally, the paramedic course will be continuously updated to reflect current clinical needs of the Service, and to maintain the minimum standards of the BPA national curriculum and HPC requirements.

The course will include a mix of residential and non-residential elements. However, in the short term and to support the initial introduction of the New Ways of Working and Future Clinical Response Models, the potential will exist for delivering the course at one of the other Service education centres should the need arise to provide for large numbers in a single geographical location.

Priority will be given to delivering paramedic training to convert existing EMTs from within the Service (see the Training Plan - on *the pulse*). As far as possible, this will be achieved through accumulation of modules to prepare EMTs for a shorter final paramedic element to allow them to qualify.

All existing paramedics will be provided with update training to enhance their skills, particularly with regard to patient assessment, to provide them with the requisite skills to deliver the level of care that supports the future operational response model (see the Training Plan - on *the pulse*).

Practice Placement Education

The Service will develop a comprehensive Practice Placement Education framework that will allow staff undertaking any form of clinical education and training to consolidate theoretical concepts in a practice-based environment. The role of practice

based educator (PPE) will continue to be established, and will be open to EMTs at Associate level, and HPC registered paramedics at practice placement educator level (see Section 8), who have an interest in supervising and supporting the development of students. PPEs will work as part of the management team on complexes, taking responsibility for a named student for the period of their development, complementing the role of team leader, station training lead and practice learning team to identify and enhance learning opportunities of their students.

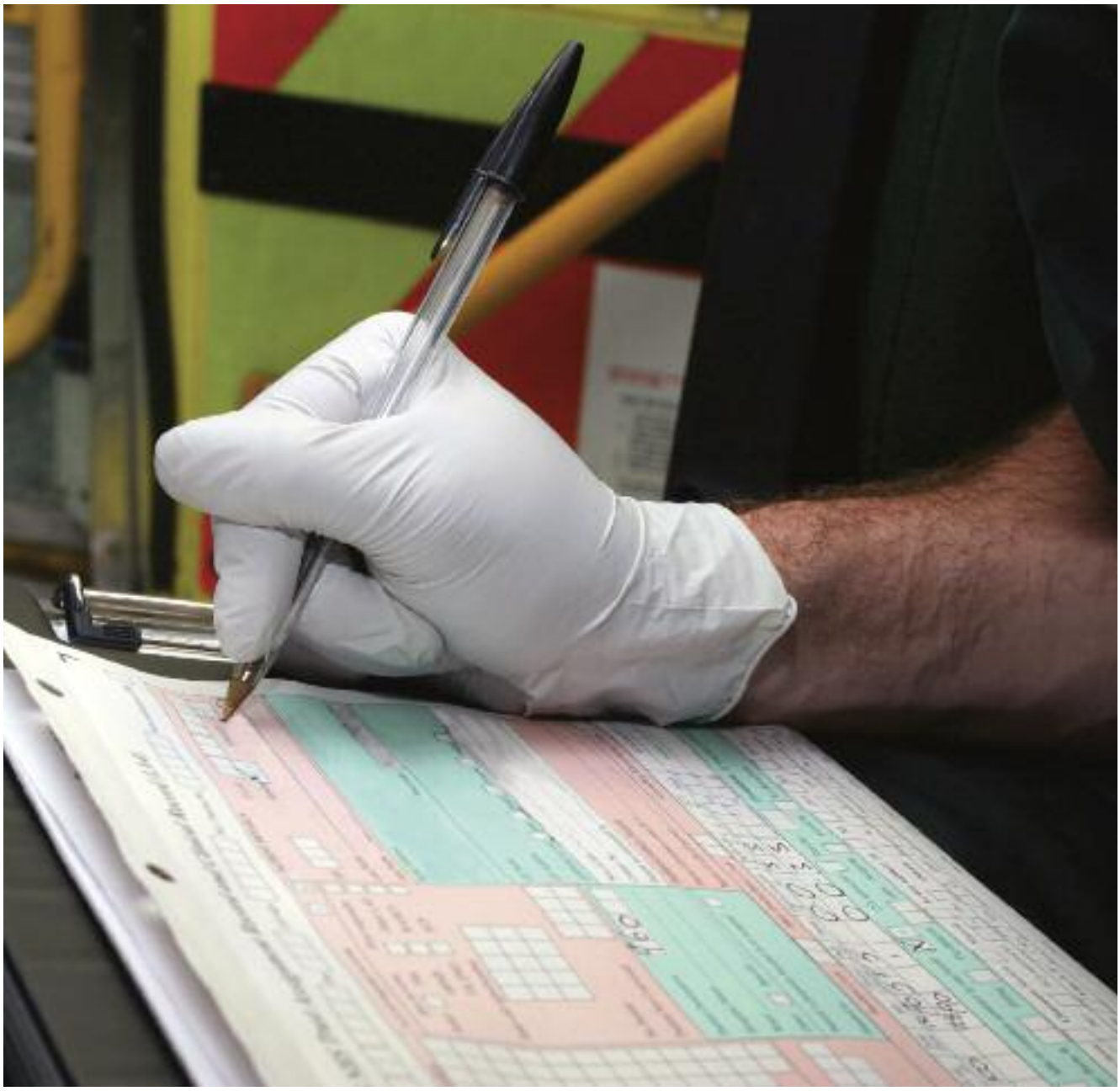
Emergency Care Practitioner Courses

The programme of development for ECPs will, as far as possible and as at least a minimum standard, reflect the national curriculum (yet to be agreed) and will be delivered in partnership with, and accredited by, one or more of the Service's HE partners.

Promotion Courses

Courses associated with promotion and career progression (team leader, DSO, AOM, Exploring Leadership & Self Awareness, etc.) will continue to be run and delivered in their current format, which is already designed on a modular basis.

5 Clinical Leadership & Support



Clinical Leadership, as its name suggests, is about two things.

The first is clinical expertise. The clinical expert is someone at the forefront of their field. Their knowledge, both broad and specialist, is of the highest standard. They accept responsibility for their own learning, and not only keep themselves up to date, but are forward thinking in the likely direction of future developments in their field. The clinical expert understands the importance of translating their knowledge into skills and practical application, and the importance of maintaining those skills, developing and honing them to be the best they can.

The second is leadership. The clinical leader is not only at the forefront of their field, but is seen as being so, and provides a visible example for others of how excellence in both knowledge and the application of skills should look. The clinical leader is forward looking, and is actively involved in shaping the future of their specialist role. Clinical leaders set the pace for change within their field. They are mentors and role models for both those new to the field, and for more experienced practitioners, providing support and challenge to poor practice through development, appraisal and feedback.

The clinical leader puts the patient and their well being, in all respects, at the centre of everything they do clinically and professionally, and motivates others to do the same.

High level Clinical Leadership & Support

The patient care/clinical leadership agenda for the Service will be led by the **Medical Director** who will provide the lead in establishing a clear direction of travel for patient care that takes into account the national, London-wide and international patient care picture. Working with the **Assistant Medical Director in Primary Care**, the **Clinical Practice Manager** and **Senior Clinical Advisor**, focus and clarity will be given to allow the Service to understand its organisational commitments as well as allowing clinical staff within the Service to understand their own individual commitments to the provision of excellent patient care.

The **assistant directors of operations** (ADOs) will have the overall responsibility for ensuring that clinical excellence and patient care are at the forefront of both strategic and tactical management within their Area. Working with the **performance improvement managers** (PIMs), **practice learning managers** (PLMs) and **ambulance operations managers** (AOMs), the ADOs will maintain not only an ultimate responsibility for maintaining a clinical focus in all the business of their Area, but will act as a champion of clinical excellence, recognising and rewarding demonstrable clinical leadership, challenging poor achievement of clinical targets, and providing equal support for clinical as for operational performance.

At station complex level the AOM will provide the clinical focus and will drive forward the concept of clinical excellence. It is through the AOM that the organisation will channel information both from the staff and from the senior management team. The clinical support provided to the AOM will come from the PLM, the station-based trainers and the team leaders.

Within Control Services a clinical support function will be introduced that will have overall responsibility for clinical leadership and governance within EOC and UOC, overseeing 24-hour clinical advice for frontline staff, agreeing and monitoring clinical performance indicators, and partnership work with the Clinical Audit and Research Unit (CARU) to oversee the Service's contribution to research and audit involving UOC and EOC including AMPDS and the DART study.

Front-line Clinical Leadership & Support

Continuing improvement in clinical leadership

within the Service will be achieved through providing not only higher level leadership and commitment, but also through appropriate and reliable resources, development, information, guidance and performance appraisal and feedback being made available to complex-based clinical and training leads, who will actually deliver the clinical leadership agenda.

Station-based trainers (title to yet be finalised) will provide the clinical expertise on each complex, being responsible for the local delivery of clinical education and training, and providing support and development to ensure the clinical and developmental performance of team leaders.

Team leaders will be provided with the means to deliver meaningful feedback to their staff not only on CPIs, but on individual clinical performance, enabling them to be a first-hand source of advice for operational staff. This will require reliable and up to date information to be available to team leaders and trainers on the clinical performance of individuals from sources such as PRF, MDT, performance information gained through appraisals, ride-outs, feedback from service users and undertaking clinical case reviews, etc. In addition, information will be made available from various sources, including specific patient outcome data (particularly around cardiac arrest and STEMI), results of clinical audit, internal and external clinical research outcomes, etc, to allow frontline staff to understand the outcomes of their own clinical performance and to inform their own perception of their strengths and their development needs.

A 24-hour telephone advice line will continue to be provided for frontline staff. This gives staff the means of speaking directly with a senior clinician at any time, and is of particular value for staff who are on scene with a patient.

The role of **emergency care practitioners** in providing clinical leadership will need a greater focus, seeing them potentially being targeted to more complex patient cases etc. This group of staff have benefited from significant clinical development and have the opportunity to act as role models and advisors to their front line colleagues in day to day patient encounters. The current small numbers and spread of the ECP cohort has minimised their impact.

Although there is clear recognition that the clinical leadership roles fall largely to the complex management team, all operational staff accept that clinical leadership is part of everyone's role, and they take responsibility for their own clinical practice and development. There are many paramedics and EMTs who, though not working as team leaders, have a real passion and interest in particular, specialist areas of their work, and have therefore developed specialist expertise that is largely untapped. The concept of **Patient Care Champion** could be a means of expanding the role of clinical leader to include paramedics and EMTs who are exemplary in their patient care, clinical knowledge, interpersonal and leadership skills etc, or who have a specific expertise in a given area (e.g. sickle cell, mental health, older people etc.), with linkages into the sponsorship for study and bursary schemes currently available.

A number of UK ambulance services are training a cohort of **critical care paramedics** (CCPs), usually in conjunction with their HE provider, and with the intention that they will work on the air ambulance or be involved in inter-hospital transfer. In view of the likely changes in the provision of specialised care in London, there is an increasing need to develop such a cohort of staff to support the decisions made to transfer patients who may well be critically ill or injured to the specialised centres referred to in the Healthcare For London 'A Framework For Action' report.

The Service will consider building on the principle of the existing cohort of HEMS paramedics, including the emeritus group. Many of these paramedics have extensive experience of advanced airway and trauma management. They are more likely to have seen injured children and been involved in multiple casualty situations.

Courses have already been developed for our existing HE providers which could support the extensive practical knowledge and skills this group has acquired.

Such a cohort would complement the knowledge and skills acquired by ECPs, who are experienced paramedics who are targeted to the lower priority, but more complex, primary care cases, giving our staff increased opportunity to develop in either, or possibly both, directions.

Clinical Audit & Research

The Clinical Audit and Research Unit (CARU) is the part of the Medical Directorate that undertakes robust scientific research projects to explore new avenues for treatments and services aimed at delivering the best possible care to our patients. Additionally, through its programme of systematic clinical audit, CARU monitors and reviews the quality of the care that is delivered to our patients and recommends appropriate changes to practice aimed at improving patient care both locally and at a national level.

In establishing enhanced clinical leadership on stations the interface between frontline managers and staff and CARU will itself be enhanced, and will allow our clinical care to be better monitored and evaluated, and information and feedback made more readily available to help inform individual practitioners' appraisal and development and thereby their practice.

Clinical Audit

The aim of the clinical audit programme is to ensure that the Service delivers high quality care to all its patients in line with best practice. Quality of care is measured in a number of ways, including:

- Adherence to clinical practice guidelines
- Delivery of patients to appropriate care providers
- Speed of response; health outcomes, and patient satisfaction

The results of all our clinical audits are used to develop recommendations for enhancing patient care. The programme is overseen by the Clinical Audit and Research Steering Group who ensure that the areas of care audited are of relevance to the strategic objectives of the Service and current priorities in pre-hospital care and the wider NHS. The findings of all audits are disseminated widely across the Service and externally to other UK ambulance services, local hospitals and other interested parties.

There are four types of clinical audit activities undertaken by CARU:

1. Central audits – large-scale multi-disciplinary audits which aim to look at the process of patient care as a whole. Some examples of previous central audits are the asthma audit and re-audit which looked at diagnosis of asthma and administration of salbutamol. Forthcoming audits will look at ET tube placement and obstetric care. These audits will be primarily undertaken by CARU, under the day to day management of the Clinical Audit Co-ordinator.
2. Snapshot audits – smaller audits focusing on a specific aspect of care or area. These are undertaken largely by the Clinical Audit Co-ordinator. However, all staff members in the Service, who express an interest in clinical audit, are encouraged to undertake a snapshot audit or become involved in clinical reviews for audits.
3. Clinical Performance Indicators (CPIs) – a continual clinical audit of the care given to patients as recorded on the Patient Report Form (PRF). This type of audit is carried out by team leaders as part of their role and is managed day to day by the Clinical Audit Facilitator. It looks at increasing the quality of documentation on the PRF and improving specific aspects of patient care which have a strong evidence base and are of clinical risk. We are currently in the process of rolling-out a set of ECP-specific CPIs.

4. We also carry out regional and national collaborative audits with other NHS Trusts to look at patient outcomes and the impact of pre-hospital care and allow benchmarking.

As part of the clinical audit programme, CARU also undertakes continuous audit of cardiac arrest and myocardial infarction cases. Through these audits we produce station complex-specific information (via the monthly Cardiac Care Pack) to enable local monitoring of cardiac care. We also produce the Service's Cardiac Arrest Annual Report that presents, along with other important information, the Service's cardiac arrest survival rate.

Within the New Ways of Working it is envisaged that CPIs will play an important role in further developing clinical care:

- A CPI champion on each station complex to liaise with CARU and to assist with the development of CPIs and give feedback to CARU
- CPI completion will regularly exceed 95 per cent
- Compliance rates will regularly achieve 100 per cent
- An enhanced system for monitoring performance against the above targets will be put in place
- Team leaders will be given the time both to undertake CPI audits and to provide quarterly CPI feedback sessions with staff
- Trainers will be given the time to produce quarterly CPI Quality Assurance checks and give feedback to team leaders as a group
- Staff will have access to computers such that they can access their own CPI data
- Robust systems of staff movement will be in place so that the CPI database can remain up to date
- PRF training and refreshers will be undertaken regularly to ensure that operational staff understand the importance of a comprehensive PRF.

Research

The Service's comprehensive research programme focuses on remodelling the way the ambulance service responds to patients and is aimed at developing new knowledge that is of benefit to pre-hospital care and the wider NHS. Findings from research are used to contribute to the evidence base for pre-hospital care and to improve patient care.

We are currently running a number of cardiac research trials in collaboration with international partners including Seattle Emergency Medical Service, University of Washington and New York City Emergency Medical Service, examining various aspects of care, from telephone CPR instructions to the use of defibrillators in the field. We are also currently developing two cardiac drug trials in collaboration with some London hospitals and drug manufacturers. Other research projects in the programme encompass areas of care such as stroke, older people who fall, and the role of emergency care practitioners.

CARU is also responsible for approving all research that takes place in the Service or using our staff or data, and ensures that the Service's research activities comply with relevant guidelines and legislation.

In order to support and encourage awareness of evidence-based practice throughout the Service, CARU runs Evidence for Practice Seminars every other month where research, audit and evaluation findings are presented. We also run a Journal Club every second month, where staff with no or limited research backgrounds have the opportunity to read and critically appraise published research papers and discuss the implications of the findings on day-to-day practices. We also hold 'Advice Surgeries' in which we answer questions and advise staff about research and audit methodologies. The seminars,

Journal Club and 'Advice Surgeries' are open to all members of staff.

It is anticipated that the New Ways of Working will lead to:

- An audit and research champion at each station complex
- The active involvement of stations in the proposal and design of research protocols, including providing logistical expertise of what is possible
- Attendance at the Evidence for Practice Seminars and Journal Clubs
- A commitment to release staff to attend the above wherever possible
- More robust systems for data collection
- Proactive administration and dissemination of audit and research projects
- Each complex will have and audit and research noticeboard demonstrating the clinical effectiveness of that particular station complexes and the Service as a whole.
- CARU will be invited to and attend station complex and Area meetings
- Management teams will actively champion the importance of audit and research projects through both actions and words.

Protected Training Time

Whilst there is always a place for both feedback and development to be given 'on the hoof,' to rely on it being fully, or nearly fully, achieved in this way is unreliable and unpredictable, and underlines any sense of it not really being valued by the organisation. To enable a structured, planned, strategic approach, providing clear, achievable objectives and measurable outcomes, a modular training and development delivery programme will be introduced, alongside protected training time built into staff rotas.

Patient Care Agenda

The Service's 'Patient Care Agenda' will be clearly stated and able to be easily understood by **all** clinical staff. It will be kept focused, involving a small number of key objectives that are well communicated, initially from the Medical Directorate and senior management team.

Both team leaders and trainers will be provided with clear objectives from AOMs and PLMs regarding the expectations placed upon them for achieving the agreed patient care agenda, both service-wide and complex-based. Appraisals for team leaders and trainers will focus on these key objectives, as will appraisals for EMTs and paramedics, and will be clearly linked with PDR.

6 Clinical Leadership on Complexes:

Role Modelling Excellence in Patient Care

Within the Service the aim is for there to be no separation between clinical leadership and leadership per se, but rather we will develop the leadership skills of those in roles requiring them to be clinical experts alongside doing the same for those in non-clinical managerial roles. The aim is:

- To genuinely establish and embed clinical excellence through leadership as the first and most important of the organisation's values
- To build the same degree of support and protection around it as is afforded to operational performance.

As part of this work, redefinition of the roles that enable clinical leadership to exist on stations will provide clarity of purpose, identify interdependencies and reliance between roles, and enable critical success factors for each role to be established and monitored.

Station Complex Roles

The station complex and its team are considered to be the face of the Service locally. The **ambulance operations manager** is the local lead for all initiatives, both clinical and non-clinical, for their complex. This does not require them to be the most clinically expert, but instead is about the emphasis and importance placed on patient care by the AOM, the tone they set on the complex in this respect being paramount in enabling the clinical experts and role models within their team to have real impact.

Working alongside the Area AOMs as a group (and in partnership with the Area ADO), the **practice learning manager** plays a key role in supporting the local patient care/clinical care development agenda, tying it in with the wider centralised framework of patient care development, driven through the Medical Directorate, to ensure both local applicability and governance needs are met as well as service-wide consistency.

Both the AOM and PLM are responsible for tying the local, complex-based patient care agenda into that of local partners, such as PCTs, PPI fora, acute trusts, social services, etc to ensure that the needs of the local community are both understood and included in providing an inclusive and complete picture of local patient care.

The role of the **station administrator** is to support the management team and staff on a station or group of stations. They manage all the administration which includes completing all pay, leave and absence returns, providing basic HR information for staff and managers, providing an administrative service to the management team and a point of contact for other Service departments and external customers. They facilitate the smooth running of a station and its satellites.

The team of **duty station officers** provide the managerial direction and support that enables the complex to function as a unit, both operationally and developmentally. The DSO role is crucial in ensuring operational performance is complementing clinical performance, and in ensuring that frontline staff have all they need to deliver optimum patient care.

The clinical expert for each station complex is the **trainer** who, as an integral part of the management team, is empowered and enabled through partnership with the AOM and PLM to set, deliver and monitor the local clinical leadership/patient care agenda. Working directly with a team of team leaders, the trainer is responsible for supporting frontline staff in gaining and maintaining the skills and knowledge they need to deliver optimum patient care.

The purpose of the **team leader** role is, first and foremost, to provide mentoring, support and visible clinical leadership to operational frontline staff. The team leader is the clinical role model for their team, which is not just about doing CPIs or formal rideouts/appraisals, but includes the example set by team leaders in all their own interactions with patients, their evident confidence in their own

clinical knowledge and expertise, as well as the way they support others to achieve the same.

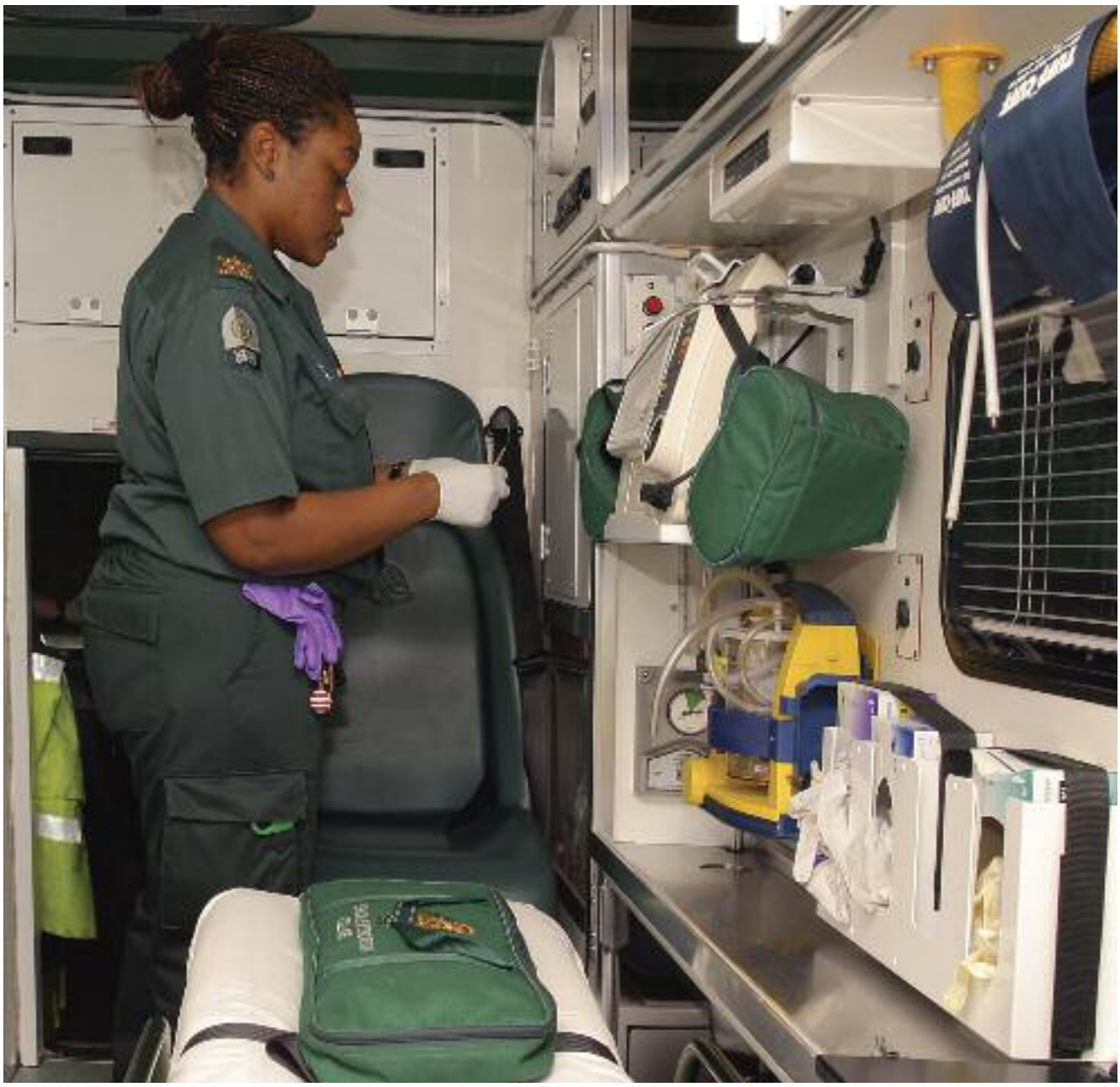
Emergency care practitioners work as part of the complex team to provide not only clinical role modelling, but also clinical support and expertise to their paramedic and EMT colleagues. In addition, they play an important role in ensuring that existing local and service-wide care pathways are promoted and used, and that new pathways are developed to reflect the emerging care needs of the local community.

On each ambulance complex there is a member of staff, the **community involvement officer**, who is designated to lead on patient and public involvement (PPI), public education and building relationships with partners in their area. The community involvement officer has good links both within the Service and externally. Key relationships within the Service are with the Events & Schools Team, the Events, Schools and Media Resources Manager, the Community Resuscitation Training Team, the Diversity Team, the Communications Team, the Patient Advice & Liaison Service and the PPI Manager.

Although there is clear recognition that the clinical leadership roles fall largely to the complex management team, all operational staff accept that clinical leadership is part of everyone's role, and they take responsibility for their own clinical practice and development. There are many paramedics, EMTs and urgent care staff who, though not working as team leaders, have a real passion and interest in particular, specialist areas of their work, and have therefore developed specialist expertise that is largely untapped.

The concept of patient care champion could be a means of expanding the role of the clinical leader to include paramedics, EMTs and urgent care staff who are exemplary in their patient care, clinical knowledge, interpersonal and leadership skills, etc, or who have a specific expertise in a given area (e.g. sickle cell, mental health, older people etc.), with linkages into the sponsorship for study and bursary schemes currently available. This would also enable practitioners to be directly involved in work that is focused on the specific health needs of the complex's local community, where particular conditions, for example diabetes or sickle cell, may be more prevalent than in other areas.

7 Workforce Planning



Overview

Having a skilled, professional workforce shaped to meet future needs and committed to both patient care and the Values of the Service is a pre-requisite to achieving our objectives. Detailed work has been undertaken to identify the likely front-line clinical workforce requirements based on modelling and planning assumptions made for the plan period 2007-2013.

Analysis has been undertaken as to the skill mix requirements for each type of potential response we provide to patients now and in the future. This has highlighted the need for a larger number of single first responders who will be given an enhanced level of assessment skills and form a greater proportion of the workforce. We will also move progressively towards a two tier system of ambulance transport with Advanced Life Support (ALS) ambulances and Basic Life Support (BLS) ambulances with an appropriate workforce skill mix. Category C patients who cannot be managed appropriately through Clinical Telephone Advice (CTA) will receive an assessment visit from an emergency care practitioner or paramedic and so an increased number of staff trained to this level will also be required.

Crew staff numbers are planned to increase over the period by around six per cent (eight per cent including the increase in CTA staff). There will be a four-tier frontline workforce: emergency care practitioners; registered paramedics, a reduced number of emergency medical technicians and emergency care assistants (title under review). This will create a front-line clinical workforce with almost 80 per cent of staff providing direct care to patients being professionally trained together with an increase in those with basic training. The majority of existing emergency medical technicians will be up-skilled through professional training to paramedic status complemented by the recruitment of university-trained paramedics.

Consultation with Staff side and a full partnership approach will be taken to progressing the workforce plan, which will be reviewed annually and will take account of any future changes to national or local policy or any new service developments, such as provision and expansion of Out of Hours services.

Further work is to be undertaken to identify future requirements for call-taking and despatch staff, Patient Transport Service staff and support department staff.

More detail on the short term and longer term plans is provided below:

Workforce plan 2007/08

The Trust will consolidate the existing expanded workforce and begin to introduce the desired change to skill mix in order to meet the needs of the new service delivery model including the Future Clinical Response model These plans currently assume no additional funding to support the changes in response time measurement (Call Connect) to be introduced in April 2008. The plan will therefore change should the Service be successful in its bid for additional funding in this respect.

The main focus for 2007/08 will be to begin the process of enhancing the skills of those staff currently in post rather than recruiting additional staff and the overall staffing numbers will therefore remain unchanged.

The costs of existing emergency care practitioners (ECPs) will be absorbed into the Service's baseline budgets so as not to be reliant on annual funding negotiations with individual PCTs. This will give the stability required to continue to develop the individuals in these roles and give the Service the confidence to roll out the ECP model further throughout the organisation in future years.

The number of paramedics is expected to increase by about 150. This will be achieved through a combination of recruitment of university-trained

paramedics and internal paramedic training of emergency medical technicians (of which the majority will be EMT4s).

Staff employed in the new A&E support role (title of emergency care assistant is under review), is expected to increase from 99 to 126.

External recruitment within this year will therefore concentrate on the paramedic role together with some anticipated recruitment to the new A&E support role and the filling of existing vacancies for clinical telephone advisors.

Workforce plan to 2013

From 2008 onwards the Service will continue the process of enhancing the skills of its existing workforce and will also begin to increase its numbers in response to the assumptions on demand and change in service delivery. Over the period of the plan the Service will:

- Increase the numbers of ECPs by 130 (one ECP scheme per station complex) in order that this role can be used appropriately, responding to the patients who require their level of knowledge and skill
- Increase the number the number of dedicated trainers on stations
- Continue the programme of university recruitment and internal training and thereby increase the number of paramedics to 1,911 (from 815 in 2007).
- Continue to develop existing technicians through the career progression route with paramedic training. This will be supported by an HR framework agreed through a joint partnership working group. Staffing numbers in both the EMT3 and EMT 4 roles will reduce over time. It is anticipated that by 2013 the majority of EMT3 staff will have progressed to EMT4 or paramedic roles and approximately 120 EMT4s will remain
- Increase the numbers of A&E support staff by 345 to 444
- Expand Clinical Telephone Advice, with double the numbers of clinical telephone advisors (100 by 2013)
- Consider within the plan staff resourcing for the Olympics, HART and Call Connect
- Continue to provide a limited number of training places for a revised EMT role to allow progression for A&E support staff.

8 Education & Development Restructure

Introduction

The context within which ambulance services provide education and training for their staff is changing nationally. With greater emphasis on the merging of internally delivered training with higher education (HE)-based development, the workforce review and the emerging financial/funding pressures for all training outside medicine and nursing, there is a need for a fundamental shift in the way that ambulance service's design, plan and deliver staff training and development.

For the Service this will mean that over the next five years:

- Greater emphasis will need to be placed on front-line staff's clinical development and continuing professional development than is currently the case
- With the proposed changes to the workforce profile and skill mix, the main focus will move to paramedic development

- There will need to be an enhanced internal capacity for upskilling EMTs, and developing existing EMTs to paramedic level (bearing in mind the anticipated increase in the academic standing of the paramedic award from certificate to diploma), and in upskilling existing paramedics to the new standards of proficiency.

The above, in addition to many other service development initiatives, is given focus in the work that is currently being undertaken to establish new ways of working, and the establishment of enhanced clinical leadership, on each station complex. This work, which commences in 2008 beginning with three 'early implementer' station complexes.

It is within this context that the changes detailed in this section are being made. The objective of the changes is to meet the above stated challenges through:

- Increasing the number of training delivery positions
- Putting more of those posts into complexes
- Modernising our use of managerial positions

Education & Training Delivery

The new structure places most emphasis on the role of education and training delivery. This is divided into two parts:

Workplace Based Education & Training

As part of the 'New Ways of Working: Transforming Clinical Leadership' programme:

- Team-based working and flexible rostering will be introduced on all complexes, with self-rostering and protected training time built into work time. As part of the station complex team, trainers will work in this flexibly rostered way
- Wherever possible a dedicated, appropriately equipped training room/learning resource will be established on each complex to allow trainers and team leaders to deliver the CPD modules for their staff on site. Where this is not possible accessibility through a local education centre will be maintained
- There will be two dedicated trainer positions on each station complex (a total of 52) who will report to the AOM, with professional accountability to the area practice learning manager. The main purpose of these posts will be to manage the delivery of all CPD activity for the frontline staff on that complex, as well as supplementing any recruitment training activity
- In addition, the posts will provide supportive and facilitative line management to the station's team leaders, with visible clinical and educational focus for the role and enabling a clear link into both education and clinical development.

The Training Services Group will continue to set the level of centralised training activity. As the majority of trainer roles will be based on stations, the resourcing of trainers onto recruitment courses based in education centres will be drawn from that pool, and will necessitate a greater degree of forward planning and cooperation between trainers, AOMs, PLMs and the resource function at Fulham to ensure that appropriate levels of trainer resources are maintained at both stations and education centres.

In Control Services, the current structure will remain effectively unchanged with the exception of changes to job titles to mirror those used elsewhere within clinical education.

Diagram 1 (overleaf) shows the new station complex level structure

(Further details of the entire departmental restructure are available on the pulse)

Paramedic Education & Training

Over the next five years a greater emphasis will be placed on:

- Enhancing our internal, HE accredited capacity for upskilling/developing existing EMTs to paramedic level (bearing in mind the anticipated increase in the academic standing of the paramedic award from certificate to diploma)
- Developing a greater degree of Service in-house contribution to the education and development of ECPs
- Strengthening our contribution and support to the Paramedic Science HE programmes.

In order to achieve this, the new structure contains a number of dedicated paramedic tutor positions whose role will primarily be to provide the previously stated paramedic programme.

These tutors will report to either the HE Programme Manager or the Education Centre Manager at Fulham. They will all be involved in all aspects of the paramedic education and development programme.

In addition to the above detailed changes to line reporting, flexible rostering (including unsocial hours) and place of work, the job description and person specification for station-based trainers will reflect the inclusion of line managerial responsibility for team leaders.

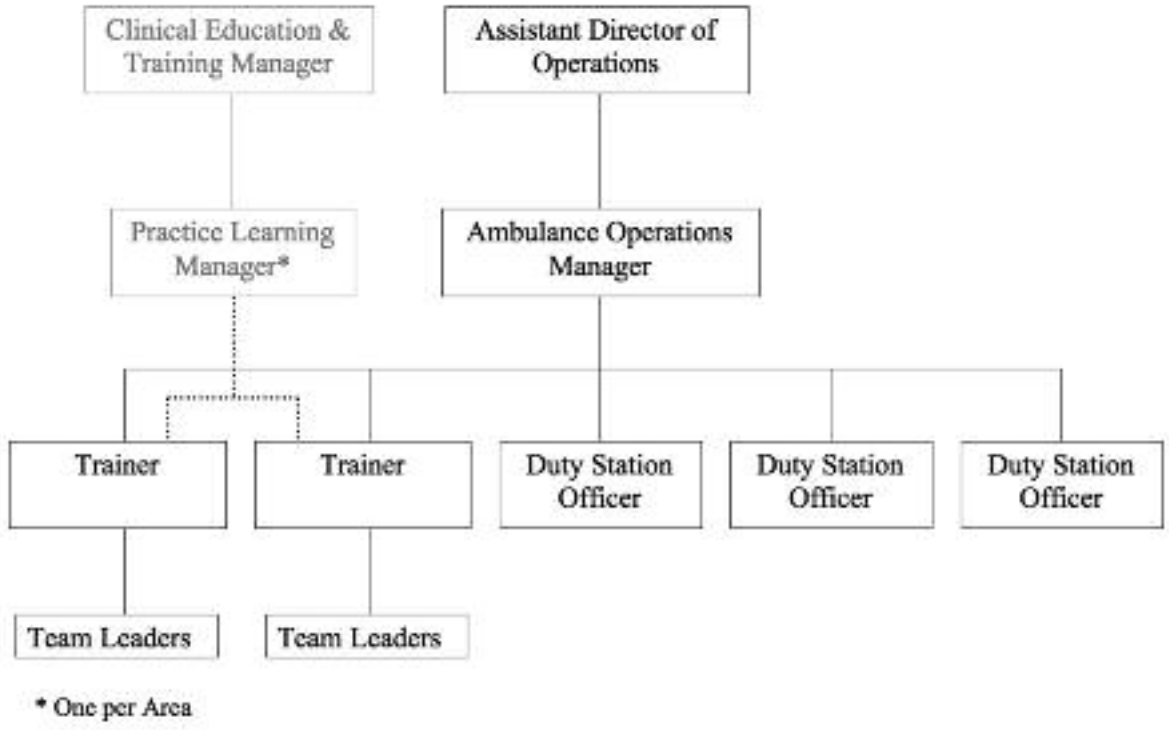
Tutor Development

Although there will be two distinct trainer/tutor roles within this new structure, a system of exchange/buddying will continue to exist that will allow trainers and tutors to interface with station, centre and university based education and development.

Course Content Development

A new steering group will be set up in early 2008, jointly chaired by the Medical Director and Assistant Director of Organisation Development, to determine the design and content of all clinical training courses and modules.

Diagram 1 COMPLEX LEVEL DETAIL



9 Working Practice Modernisation

In order to achieve the vision for clinical leadership on complexes, there are a number of existing practices that will need to be modernised to allow new ways of working, teamwork and leadership to emerge and be developed.

Working Patterns

Current working patterns (rosters) do not allow for many of the core principles of good leadership to be fully developed, including good, reliable face to face communication, consistent management and leadership, genuinely flexible working arrangements, the development of strong relationships between people, and the establishment of real teams.

The following describes how the above could be achieved through changes to working patterns, including the potential introduction of a watch system, self-rostering teams, and annualised hours.

Self-rostering teams

Traditionally crew staff are placed on a station roster after having served their time on a relief roster. Once given a permanent shift line on the station rosters, staff would remain with the same crew mate and would follow the same shift patterns with set rest periods and set shifts. This is not a flexible system and invariably leads to either too little or too great a resource on duty for the demand at any given time. With the current rosters we very rarely achieve congruence between resources and demand. Self-rostering will provide teams with the opportunity to better match available resource to demand by providing greater flexibility, which can be predetermined by the team members themselves who will decide their own shift patterns.

Effectively each team would be contracted to provide an ambulance or a single response vehicle 24 hours per day 7 days per week. A relief factor would be included within the team make-up so as to provide for annual leave, training and development and an anticipated level of sickness absence. Each team would comprise of 14 members, including the team leader - this number is based on having a 30 per cent relief factor for each ambulance or two single response units. Within the current roster provision there is a requirement for 9.6 WTE per week to provide one ambulance 24/7 (based on the 39 hour week), this accounts for 10 of the team, the additional team member's account for the 30 per cent relief requirement with the team leader being supernumerary, giving greater flexibility for clinical supervision.

The team members would cover their own absences to ensure that the vehicle is always available; this of course may at times require the support of a centralised pool of relief staff or by the release of additional overtime hours for team members. This would occur when the absence levels in the team exceeded the inbuilt relief factor, however in most cases an unexpected absence within the team would be covered by a team member. Certain parameters may need to be agreed so as to ensure a balance of provision across the teams within a station or complex such as ensuring all the vehicles do not start and finish at the same time etc.

Within pre-determined parameters such as minimum cover requirement, maximum and minimum shift lengths etc, the team members themselves would decide what shift patterns are worked and what length the shifts will be. To maximise flexibility there may well be, built in to the team contract, provision for additional shifts or for dropping of shifts at the request of the complex management team based against increases or decreases in demand.

Advantages

Self-rostering teams as described are best suited to the provision of a 24-hour vehicle in that the team contract is for exactly that. Team members can truly decide when and how long they work for as long as the vehicle is staffed. However, to manage this process effectively team members would need to be placed on an annualised hours contract.

Annualised Hours

Annualised hours is a method of organising work over a period of one year calculated on the basis of the number of hours to be worked rather than the number of hours per week. This allows for greater flexibility to meet individual needs within a team but also meets the varying demands of the Service. The actual number of hours worked by each team member in a given week can be flexed to match workload requirements and individual availability, although the average working hours will need to comply with the Working Time Directive. The basic principal of annualised hours is that instead of defining the traditional working week as 37.5 hours a commitment is made to provide for a set number of hours per year. This principal can be further defined within a quarterly period or even a monthly period. As previously stated there will be the need for predetermined parameters such as maximum and minimum shift lengths, maximum hours worked in any one week etc.

There is a standardised formula for calculating the contracted hours for staff and as an example a member of staff with less than five years' service on an annualised contract would be paid for 1,955 hours per year and be contracted to work for 1,693 hours per year, the difference being annual leave and bank holiday entitlement.

Advantages

Annualised hours schemes are especially attractive in areas which have uneven demand or seasonal variations.

Advantages to the Service would include:

- Increased flexibility with core resources
- More predictable pay costs spread evenly throughout the year
- Less reliance on temporary staffing solutions.

For staff, potential benefits include:

- Stable income
- Potential to take time off when needed e.g. school holidays
- Improved work/life balance

The Watch System

A watch system is devised by splitting the total number of staff within a unit, department, station or complex into teams of equal or near equal size in number. Each team or watch is given its own identity and a management or leadership structure to oversee and co ordinate the work and tasks of the watch or team. The watch leader is responsible for all of the good management associated with leading a group of people, such as welfare, training and development, mentoring and performance management for example.

A clear example of a watch system already exists within the Service. Staff within the Emergency Operations Centre (EOC) already belong to a watch team, each headed by an AOM supported by two operation centre managers. The total numbers of staff within EOC are divided amongst five watches so at any one time approximately 20 per cent of the workforce is on duty. The watch system ensures that this 20 per cent all belong to the same team. Both Police and Fire services operate the watch system in various forms but these watch systems include an inbuilt relief factor which could result in the potential to have more resource on duty than required but in reality is absorbed by annual leave, training and development and other absence such as sickness.

One of the weaknesses of the watch systems described is the need for a rigid roster system i.e. all team members need to be on or off duty at the same time and it could therefore be perceived as inflexible. However, with vision applied there is no reason why we could not adopt a watch system with some inbuilt flexibilities. For example, we could set a minimum cover level with the watch team producing greater hours than resource requirement for this minimum, and flex this against the optimum cover when demand dictates. This would require us to absorb relief into the watch team to achieve this level of flexibility. It could be that at any given station there is a requirement to cover two ambulances and two FRUs 24 hours per day, seven days per week. This will require at least six staff of the watch on duty as a minimum. However, if the plan was to have nine on duty we could provide additional vehicles at periods of high demand or build in development opportunities for the surplus resources at periods of low demand. This invariably will be early shifts on some weekdays.

Advantages

All staff would belong to a team and would be on duty at the same time. This would foster team spirit and may produce an element of healthy competition between watches which could improve all facets of performance. Communication of all issues could be more easily achieved face to face in a timely fashion. The unpopular relief system could

be disbanded with all staff now being part of the watch team. This would also remove the previous practice of having a permanent crew mate as potentially anyone could work with anyone else on a daily basis, dependant of skill requirement. There would be an inbuilt flexibility that could result in changes to duties on a shift by shift basis, aiding processes such as the PDR.

An additional advantage to a watch system where healthy team spirit and pride in collective working is evident is the potential for not wanting to let the team down and this could lead to lower absenteeism and better individual performance on response times and hospital turn around brought about by peer performance.

Self Rostering team vs. the Watch team

There are of course some difficulties to overcome in introducing any new schemes and clearly self-rostering schemes do not sit easily within a watch system. The watch system requires all staff on duty at any given time to belong to that individual watch. This requires a more rigid roster system and follows what already exists in our own EOC. However, certain changes could be engineered such as watch members self allocating against the shift requirements of the predetermined watch roster, thus giving some personal flexibilities.

The advantages of a watch system previously discussed and simply put are that team spirit is more easily fostered and communication with watch members can be achieved face to face more easily.

Self-rostering teams working in the way described will not be on duty at the same time, indeed by design only two or three will be. However, the strength of this team is developed by mutual interest and benefits to individual team members. With strong leadership and good communication links self-rostering teams may be as effective as a watch team but may, if developed well, provide greater flexibilities to match demand patterns. Self-rostering teams will not only require a high calibre of team leader capable of managing complex rostering and resourcing issues, but will also require a high degree of individual self discipline from team members if this effectiveness is to be achieved.

Whichever system is adopted, there will be a great deal of work required to successfully design and implement what will be considered a significant cultural and practical change to long established practice. There is a full programme of change to work practices which underpins new ways of working in teams, including:

- Dynamic deployment of vehicles where staff accept they will be mobile for most of their shift returning to their base only for their rest break. To maximise the benefits of dynamic deployment this will be linked with the introduction of technology for the automated dispatch of ambulances similar to that which already exists for the fast response units

- The rest break agreement will be revised to accommodate dynamic deployment and within the revision staff will be encouraged to take responsibility for ensuring they have a rest break

- The annual leave arrangements will be reviewed in light of whichever team system is chosen to ensure that all leave is taken within the leave year and that when leave is taken it is more evenly spread across the shifts and within the team relief factor.

Much of this work is already being planned or is at the stages of early discussion and should be viewed as a springboard for new ways of working within teams.

Organisation Development & Leadership 10

Through the introduction of the New Ways of Working, and the specific elements of the Organisation Development (OD) & People Programme that forms part of the Service Improvement Programme 2012, the following key areas of OD will have a different look and feel in the Service of the future, not only on station complexes but throughout the organisation.

Performance Management

Within the Service, performance management will be perceived as a positive, comprehensive system through which good performance and the achievement of personal, business and development objectives are identified, recognised and rewarded, and through which below standard performance and non-achievement of objectives is fairly appraised and monitored, with appropriate support and development available, and clear and consistent performance capability processes being applied where necessary.

All staff, regardless of position within the organisation, will be provided with regular performance appraisals from their line managers, tying in progress achieving business objectives with achievement of personal development targets. There will be active promotion of the use of real and comprehensive performance management as a means of motivating staff in the achievement of both personal and wider departmental and organisational objectives and goals. In a wider sense, the same will be applied to team as well as individual performance.

Talent Management & Succession Planning

The organisation will put in place a framework of access to dedicated, targeted development for any member of staff from across all departments who has been recognised (or who recognise themselves) as having the raw talent for leadership.

Through a process of initial selection and appraisal, the strengths and potential of these individuals will be explored, and with their managers, a development plan will be designed that enables them to work toward reaching that potential through promotion.

Staff on this programme will become part of an accelerated promotion pool, based purely on strengths and ability. This will enable managers to anticipate who the future leaders of the organisation are, and provides talented managers who know and understand the organisation.

Through this programme, the organisation will be better able to:

- Recognise and capitalise on talent
- Allow staff to progress in their career according to their choice and at their own pace
- Provide accelerated development and progression for talented staff
- Provide development for staff wishing to take part in accelerated progression
- Anticipate upcoming vacancies and/or development opportunities
- Target staff at specific opportunities and vacancies
- Provide equitable access to opportunities for progression
- Initially recruit to selected managerial positions from the accelerated promotion pool.

Leadership & Management Development

Whilst a transactional, managerial approach is sometimes necessary, and is an important part of any leader's toolkit, it will no longer be the default style for the Service, where empowering, transformational leadership will secure the prevalent style. We approach the leadership of the organisation in the same way we approach patient care - that is, by engaging and communicating with individuals to better understand and meet their existing and emerging needs, and by motivating and inspiring them to develop both themselves and the organisation to enable continual growth, effectiveness and success. In addition, the senior management team will act as role models, providing example of transformational, values-based leadership in action.

To this end the Service has planned its own comprehensive Leadership & Management Development Programme comprised of the following elements:

1. The Exploring Leadership & Self Awareness (ELSA) programme for middle managers and the complementary programme for senior managers (currently being designed). With self-awareness being a fundamental, base component for quality leadership this programme provides the means for ongoing development of effective leadership skills in managers at both middle and senior positions within the organisation

2. Development for clinical leaders (i.e. clinical trainers and team leaders), based around the Certificate of Education for trainers, and the Institute of Leadership & Management (ILM) Certificate in Team Leading for team leaders

3. Specific training in performance management for all managers

4. Provision of self-awareness development for all managers. A complementary strand to the

ELSA programme, which has limited accessibility (i.e. places on courses), this development allows a variety of self-appraisal tools to be made available to all managers to enhance their PDPs and provide a grounding for further leadership development

5. Provision of coaching development for senior managers and BME staff. The Leadership Development plan includes promoting and maintaining a coaching culture within the organisation. Matching non-operational and operational managers, this programme aids information sharing and cross-functional working. Our ability to coach internally has reduced the need to draw on external resources, reducing ongoing costs

6. Provision of a modular Management Skills programme available to all managers and delivered in-house. There are a number of elements available (e.g. time management, conducting appraisals etc) that are delivered through a combination of facilitated coursework and self-directed distance and web-based learning. Elements are combined to provide specific courses for new managers in particular roles (e.g. AOMs).

Self-managing Teams

As a consequence of a prevalent transformational leadership style and use of comprehensive performance management, the degree of local empowerment of teams will grow steadily within the Service. There will be a real sense of teamwork across all departments. Local leaders will know their teams well, and will themselves be known by their teams. Team members will be better able to understand each others' preferred ways of working, exploit each others' strengths and balance each others' weaknesses. Teams provide supportive yet challenging environments which stretch each team member to give their best, and strive to be better.

There will be minimal centralised management directly affecting teams, and micro-management by senior managers will become a thing of the past. Local managers will be provided with the skills and resources to manage their team's performance to meet organisational, as well as specific departmental and team, objectives. These objectives will be known by all team members, and through each leaders' use of appraisal and feedback, each team member will be enabled to understand their personal role in the team's achievement of these objectives.

Members of successful teams trust each other. Those leading successful teams trust their senior managers. Local managers will not be second-guessed by senior managers. There will be an acceptance of diversity in reaching goals; not every team will do things the same way. Rather than being seen as risky inconsistency, this will be viewed as adding richness to the culture, encouraging innovation and producing results, and learning from those results, that would be impossible if every team was constrained by doing things the same way.

Within the Service the goal is for teams to be real, happy places to work within. Teamwork, and the trust it engenders, hand in hand with real leadership and staff development and performance management, will become a key enabler in our successful programme of cultural change across the organisation.

11 Access programme – Delivery for the New Ways of Working: Clinical Leadership on Complexes

Introduction

This section sets out a high level vision for how the Access Programme will support the 'New Way of Working.' It suggests how the Service could derive real business benefits utilising IM&T systems and services from 2009 and beyond. Each component is written as an independent issue, not in priority order.

Key components

- A new suite of services will be available for people who do not speak English, and/or who cannot use the telephone as an able bodied person would. This includes direct internet services, and text messaging via translator services that then interact with the control room. New national targets have been agreed for these types of calls as eight minutes from initial call answer is recognised as being not realistically achievable.

- Electronic PRFs are fully installed in all response vehicles. Details of the call automatically populate the ePRF 'tablet' (hand portable PC device) and where patient details are known, appropriate medical information is downloaded from the Spine. Mandatory fields ensure 100 per cent data compliance. If the patient is to be transported then all recorded details are downloaded to the receiving centre (hospital or urgent care centre of some type), estimated time of arrival is automatically calculated, hence reception staff know who to expect and when.

- The ePRF tablet also acts as information centre for the paramedic. It has access to various clinical guidelines, and provides basic translation software for deaf people and commonly used languages. It is in continuous development as a vital paramedic aid.

- Staff training and education has evolved. All employees are required to have a basic level of IM&T literacy, irrespective of their role (e.g. e-mail, basic word processing). Many training modules are now delivered by web based e-learning packages, including many clinical modules. Traditional classroom based training is still delivered, but it is more of an exception rather than normal practice. Importantly, staff accept that they are responsible for their ongoing training – this is not something that is 'done to them' by managers.

- The Service has fully implemented Airwave. Every crew member carries a digital radio that provides point to point communication for crew members, direct access to the control room and a panic button in case of emergencies. Data is now routinely passed across this system alerting staff to calls, and in the case of non-MDT vehicles, passing the actual call details.

- ESR is the single repository for all staff data, including records of personal issue equipment. Application forms are now all electronic and from the moment of initial enquiry, the entire employee process is automated. Extraction routines take data from ESR and populate other systems that need data about people (e.g. telephone directory). This includes setting the access level that each member of staff has for information systems. Self service is fully implemented, allowing staff to self-manage certain personal attributes (e.g. bank details, address, telephone extension).

- All staff book on/off duty electronically, time recording will therefore automatically satisfy the requirements of the Working Time Directive. Additionally, when booking on duty all clinically qualified staff will be issued with an Airwave radio, that in turn will show their availability to the CAD system. All clinically-qualified staff will be expected to be available to respond to local calls to perform physically local BLS duties, irrespective of their other duties.

- All managers who have a justifiable business requirement will have a laptop computer equipped with full remote access, allowing 24/7 access to all corporate services. All staff will have access to basic e-mail (known as web mail) from

any internet terminal – essentially giving free access to Service e-mail from home computers or internet cafés. Vitally, a new culture will have emerged where staff use this technology to work smarter, not harder – this access will not simply be work added to the 'day job'.

- The concept of IM&T Super User is now well established. This role is a recognised responsibility undertaken by appropriate staff at each main Service location. The person provides local user support and has a direct liaison with the IM&T Customer Services Department, who provide ongoing support and training.

- There is a 24/7 IM&T Support desk that acts as a single focal point for all IM&T support. Utilising interactive tools the support technician is able to remotely access the faulty equipment or service. 70 per cent of the calls receive a 'fix' at the point of the call being received. That is, the technician is able to restore at least a basic service to the customer, and where necessary complete fault resolution to be undertaken in slow time. Increasingly customers will use 'self service'. Through a web browser they will be able to log on to the service desk and report their problem. They will also be able to access a series of tools and help scripts to assist in 'self fix' and also monitor progress of their fault.

- 'IP' communications has enabled the Service to implement a fully integrated digital network. Voice, data, video are seamlessly passed between Service locations, and four digit dialling connects any voice device (not necessarily a traditional telephone). 'Hot desking' is common place, with staff having a transportable telephone number (can by moved to any fixed or mobile handset) and are able to log onto their user accounts and files from any Service PC.

- There is a new, fully integrated CAD system supporting two control rooms (each with 100 per cent spare capacity for resilience). Reliability is 99.9% plus with complete system failures now unheard of. New functionality is released twice a year through upgrades provided by the commercial provider of the CAD software.

- All data is input once, as close to the original collection point as possible, normally via a web browser. Hence through streamlined business processes and work flow applications paper forms are no longer sent to data input functions. Once entered, data is then re-used by a defined suite of systems, hence removing the need for duplicate data entry.

- Management Information is provided by a suite of reporting tools that reside on all desktop and remote access computers. There are different levels of tools, and staff are able to generate reports as and when they require them, according to their access rights. The central Management Department provide expert analysis for the most complex queries, report on overall trends, provide predictions, continually develop the tools and act as guardians of data standards

- Software provision is split between in-house developments (normally under six months from concept to delivery) and commercial packages. Large scale bespoke software development is not undertaken and where necessary, business processes are adjusted in order to implement package solutions.

New Ways of Working:
Operational Support for Station Complexes

12

Operational Support is being transformed by a number of initiatives and corporate projects to support the new front end Operational Model and Clinical Leadership model.

Fleet, Logistics, and Make Ready are gradually being integrated into a single command unit to improve co-ordination and achieve maximum synergy. Geographically-based operational support centres are being considered to support the corporate OSD structure in delivering customer-focussed services.

There is a comprehensive review of Fleet Support Services being undertaken which is considering the future sizes and numbers of workshops, staff levels, hours of work, and additional services. Larger workshops, increased hours of work, additional mobile workshops, and a 24/7 call centre are being planned. Ensuring that vehicle resourcing is managed and maintained will be a key task.

Logistical support will be delivered centrally by an integrated Tender/Equipment Support Personnel Service operating from the Logistics Support Unit. A robust relief factor will be introduced to ensure services can be fully maintained. The merged operation will cover all services such as drug pack exchange, equipment exchange, blanket exchange, and post collection/delivery. Medical consumables will also be managed centrally and local stores maintained to minimum/maximum levels by Logistics staff. The Logistics Support Unit will operate a 24/7 service. Electronic asset tracking and inventory control projects will be implemented to improve oversight and make efficient use of resources.

The local Operational Support Centre will contain a fleet workshop, Logistics Co-ordinator, and Make Ready operative. Vehicles will be deep cleaned when they come in for servicing. Daily cleaning and equipping will be carried out by mobile services. Spare vehicles will be held at these centres.

Partnerships in Health and Social Care

13

We are witnessing big changes in London's health services. Fewer hospitals will provide full A&E services but there will be more places where people can get treatment for minor emergencies. And the aim is that, in order to provide the best care for people with serious conditions like major trauma, stroke and acute coronary syndromes, we will be taking patients to specialist units which may not be the nearest hospital, but will be geared up to be the best.

So, the automatic assumption was that all our patients would go to an emergency department, and pretty much the only other option was to leave them at home.

Ambulance staff will in future have a much bigger range of options for their patients and much more training to support good decisions about which to choose. Ultimately we will arrive at our patients knowing that we are better able to provide what they actually need.

In fact we will usually know a good deal about them before we get there, because we will have access to lists of patients with long term and terminal conditions, alongside real-time access to health and social care databases. This means that if, for example, the patient is under the care of a community matron for their chronic respiratory condition, we will know what clinical signs and symptoms would be normal for that patient and we will be able to contact their community matron if we don't think they need to go to hospital. This will make our clinical assessment much more thorough and better-informed.

Also, if a dying patient has chosen to be put on a register, we will know ahead of time if they would prefer to die in their home, with their family around them, and we won't be taking them to hospital against their wishes.

If a patient does need to travel we will be able to take them to minor injuries units and walk-in centres, urgent care centres, and polyclinics instead of the emergency department. We will also be able to refer them to district nurses, psychiatric crisis teams, falls teams and intermediate care – schemes designed to support patients in remaining independent in their own homes. We will have links to community matrons who support patients with long term conditions so that they are much less likely to require hospital admission. Many GPs will have made appointment slots available for the patients we go to and will become available to consult with over the phone. We will also have links with social services and voluntary sector groups.

Ambulance staff will be much more familiar with how these services work, often because the nurses and other professionals have provided training and familiarisation. Continuing Professional Development of ambulance staff will include time spent with these teams to gain a fuller understanding of how they work and which patients they can accept.

As clinical leaders, team leaders, trainers, and ECPs will be able to provide support and advice in the decision-making required. They will more often be involved in negotiating the arrangements in the first place and will be able to ensure that the guidelines for referral are kept up to date and used appropriately. They will be able to resolve any differences of opinion and follow up any problems that are experienced.

The AOM will be a regular member of the PCT's urgent care network and it is part of his/her role to seek out new opportunities for co-operation with other parts of the health and social care system.

14 Community Engagement

On each ambulance complex there is a member of staff, the community involvement officer, who is designated to lead on patient and public involvement (PPI), public education and building relationships with partners in their area. This is a full time, dedicated role. Post holders do not get drawn into dealing with operational pressures or other tasks. In fact they do not have to have a Service operational background to be selected for the role.

PPI and public education is now 'core business'. There is a budget, held on the complex, allocated to meet the costs of community engagement work. The community involvement officer reports directly to the AOM and his or her performance is monitored against clear objectives and a Personal Development Plan.

The community involvement officer has identified other people on the complex who (a) already enjoy

doing PPI and public education work, and have the skills to do it well and (b) those who would like to get involved, or for whom it would be a good development, but whose skills and knowledge need to be improved. In this way, no-one who is interested in this work is excluded. All of the people so identified have PPI and public education work in their Personal Development Plans and personal objectives, and are supported to develop and to participate in this work.

When they take part in PPI or public education activity, staff get paid for it as they would if they were working a normal shift. Staff are no longer expected to do this work for nothing, as it is recognised as being of enormous benefit to the public, as well as helping the Service to comply with legislation, achieve its external targets and its own strategic goals.

The learning from PPI and public education activity is not restricted to this group of people, though. The community involvement officer, working with the AOM, runs regular information-exchange sessions with all staff on the complex. Staff are kept informed about the health needs of the local population, about the learning from recent PPI and public education events, and about the feedback people from the community have given about the Service. Other managers are sometimes invited to these meetings (e.g. PPI Manager, Diversity Manager), as are key partners from other organisations … and patient representatives of course.

The community involvement officer has good links both within the Service and externally. Key relationships within the Service are with the Events & Schools Team, the Community Resuscitation Training Team, the Diversity Team, the Communications Team, the PALS Team and the PPI Manager. Quarterly development sessions are held for all the community involvement officers, to ensure they have opportunities to share learning from their areas and can get some central input in terms of key messages and materials. There is a central resource bank for materials (pictures, "give-away" items etc) and other key information is available on the public education pages of *the pulse*.

Externally, the community involvement officer has worked hard to get to know their counterparts at the local authority, the Overview and Scrutiny Committee, PPI leads in the PCT and local hospitals, the other emergency services, voluntary sector organisations and patient groups (e.g. expert patient networks). As Local Involvement Networks (LINks) are developed, the community involvement officer makes sure, along with the AOM for that complex, that the Service is represented on that group. LINks are a good way of recruiting patients for PPI activity both locally and centrally.

The community involvement officer also has a role in addressing the needs of frequent callers to the Service in their area, working with the PALS Team and other agencies to ensure a care package is developed for them. He or she also liaises with the Service Development Team about the development and promotion of alternative care pathways in the area. Working with the PALS Team, the community involvement officer has a role in acting on staff concerns via the incident reporting system, for example liaising with care homes or GP surgeries. He or she also works with Service colleagues and external partners to review the status of patients previously identified as posing a possible risk to staff.

The community involvement officer also has links with informal networks, and has got to know people in local business, sports facilities and social enterprises, as well as support groups for people with a variety of medical conditions, older people's "tea clubs", residents' associations etc.

Staff on the complex are encouraged to attend local public events. The community involvement officer hears about these in plenty of time to arrange for staff to be released from operational duties, as he or she has built up such good links with a variety of community groups. Staff are therefore developing a good understanding of the

people they serve, and 'us and them' tensions are diminishing.

When a large public event is being planned, the community involvement officer liaises closely with their AOM, the PPI Manager, the Events & Schools Team, Diversity Team and community resuscitation training officers in their area, to ensure the Service stand has the right materials, messages and activities to meet the objectives of the event, the needs of the community, and Service objectives. For all events, he or she ensures that a risk assessment and event plan are completed.

When planning his or her activity for the year, the community involvement officer uses the data available, to ensure that PPI and public education activity in the area reaches those with the greatest need, setting and agreeing clear, measurable objectives. Information is available from the PCT on the health needs for the various populations in the area, and this is linked with the government's health priorities and helps the Service to meet its requirement (in Standards for Better Health) to reduce health inequalities. As well as information from the PCT and local authority, the community involvement officer also uses Service data: ethnic monitoring information, PRF data, EOC call data, clinical audit data, and information on Language Line usage. This helps to determine priority areas for PPI and public education activity. Ad-hoc requests for visits from non-priority groups are only undertaken if there is a gap in the plan.

The community involvement officer facilitates visits to the ambulance station, and holds occasional 'open day' events there, inviting members of the local community via the links he or she has already made, plus advertising in local media (including non-English and specialist ones). This gives staff at the ambulance station the opportunity to meet the public on an occasion when they are not ill, helping to emphasise that 'patients are people' and potentially leading to greater respect and compassion towards members of the local community.

Working with the Community Resuscitation Training team, the community involvement officer runs basic life support training sessions for community groups, mother and baby groups, expert patient networks, and many others. They set targets (numbers) and priorities (target groups) for the year and this plan is regularly monitored. Their activity is recorded centrally so that it can be easily accessed and used to plan future activity. The training sessions are also used as an opportunity to obtain feedback from participants, not just about the training, but also about any experiences they may have had of using the Service. They are also an opportunity to find out from members of the community what PPI and public education activities they want or need.

Similarly, the community involvement officer works very closely with the Events & Schools Team. School visits are planned in advance, again depending on the local priorities and target communities, and the schedule for these visits is recorded electronically and shared with the community involvement officer and the local community resuscitation training officers. Representatives from these three groups (community involvement officer, Events & Schools Team and local community resuscitation training officers) meet regularly to plan their work, discuss joint working opportunities and share learning. As well as focusing on schools and colleges, the community involvement officer - with support from the Events & Schools Team - has built up links with local youth groups.

Once a Public Education Coordinator has been appointed (as recommended in the Public Education Strategy), the Coordinator will ensure those records are maintained, kept up to date and held centrally for others across the Service to access.

Public education activity is closely linked with the recommendations of the Public Education Strategy. Some of this activity is information-provision, explaining to communities how to use the 999 service and also how to access other services, and which is appropriate in different circumstances. The

focus of this activity is not to put people off calling 999, or trying to divert them to other parts of the system. The way this message is delivered will include letting people know that we are here to help.

Some public education activities are carried out jointly with the PCT and/or local hospital. Together we provide information about keeping healthy, as well as what to do when people are unwell. One way of doing this is through 'roadshow' events, where Service and PCT (and perhaps social services) staff go together in a vehicle to some of the more deprived housing estates, to provide health information and advice on people's doorsteps. This is a way of reaching people who have limited opportunities to go out.

The community involvement officer, with support from the PPI Manager, Equality & Diversity Manager and Events, Schools and Media Resources Manager and Communications team, is in discussion with the PCT and other NHS partners about getting key messages out on local radio, TV channels and in local newspapers. A number of DVDs have also been made, which can be used in different settings for a variety of audiences.

Patient representatives attend complex meetings, and have a say in local developments right from the start, e.g. when an ambulance station is being moved or upgraded. Of course, wider consultation also takes place when there is a significant change afoot. Once people have taken part in this kind of local involvement, they may wish to become involved with more central Service developments. There is a mechanism for details of people wishing to become more involved to be passed to the PPI Manager, who co-ordinates and advises on Service-wide PPI activity. The Community Involvement Officer is responsible for making this happen. Along with LINks, this is an important way of starting a membership list in preparation for the Trust applying for Foundation status.

Some PPI activities are more informal. These include sporting events between Service staff on the complex and the local community. There are cricket and football competitions, and Service staff also get involved with fund-raising campaigns for local community groups and charities.

As there is a central record of all these activities, it is easy for the PPI Manager, Head of Governance and others to obtain information about them. This is used to provide evidence for external bodies (e.g. the Healthcare Commission) and also to ensure that this work gets the recognition it deserves within the organisation, through reports to the Trust Board and Clinical Governance Committee. Through the reporting mechanism, it is possible to identify trends and key issues emerging from the public, which are fed regularly back into the organisation.

The community involvement officer has been trained in evaluation techniques and uses a variety of methods to ensure his or her PPI and public education activities are meeting the needs of the community. Evaluation reports are stored centrally and key learning points are extracted from them and shared centrally on the Public Education pages of *the pulse*. As a result, the Service's PPI and public education activity is constantly evolving and improving.

Details of the application process for stations, along with regularly updated Frequently Asked Questions, can be found on *the pulse* (http://thepulse)

If you have any queries or questions regarding the New Ways of Working project, please email NWOW.project@lond-amb.nhs.uk

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