

**London Ambulance Service NHS Trust
Winter and Flu Planning Framework 2009/10**

Appendix A

Glossary

Acronym	Term
LAS	London Ambulance Service
UOC	Urgent Operations Centre
EOC	Emergency Operations Centre
AEU	Ambulance Emergency Unit
FRU	Fast Response Unit
CFR	Community First Responder
MPDS	Medical Priority Dispatch System
PSIAM	
NCC	National Co-ordination Centre
ili	Influenza like illness
ACEG	Ambulance Services Chief Executives Group
MOU	Memorandum of understanding
PPE	Personal protective equipment
REAP	Resource Escalatory Action Plan
NDOG	National Director of Operations Group
EPB	Emergency Preparedness Board
ECA	Emergency Care Assistant
BLS	Basic life support
DH	Department of Health
SHA	Strategic Health Authority
NHSL	NHS London
PCT	Primary Care Trust
ED	Emergency department
A&E	Accident and emergency department

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Appendix B

DH 999 Demand Modelling Predictions for Winter 2009/10

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The slide is titled 'Background to the project'. On the left side, there is a vertical green bar with the text 'CA & I Team' written vertically. The main content is a bulleted list:

- Remit
 - Estimate the impact of a pandemic outbreak of influenza-like-illness (ILI) on the demand for individual ambulance services.
 - Provide ambulance-trust level estimates of expected pandemic levels of:
 - > 999 ambulance calls
 - > Incidents/responses (calls that result in an emergency response arriving at the scene)
 - > Conveyances (emergency and urgent patient journeys)
- Components of interest which have not been modelled
 - Impact of the pandemic flu on supply-side staffing and vehicle provision
 - Impact of pandemic-associated increases in demand and decreases in staffing on performance against operational standards
 - Effectiveness of possible mitigating actions against the pandemic

A small number '3' is visible in the bottom right corner of the slide.

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Headline figures

Assumption	Illustrative numbers, England	Data source for assumption
30% of population will become symptomatic during a pandemic, and of these symptomatic cases:	Of the 51.5m people in England, roughly 15.5m will become symptomatic. And of these 15.5m:	SPI-M pandemic planning profiles
15% will consult a GP	Roughly 2.3m will consult a GP	SPI-M pandemic planning profiles
6.0% will call an ambulance	Roughly 1.1m will call 999 for an ambulance	London Ambulance Service; QSurveillance; NPPS
4.0% will receive an emergency response at the scene	Roughly 0.6m will receive an emergency response at the scene of the call to 999	London Ambulance Service; QSurveillance; NPPS
2.6% will require a conveyance from the scene	Roughly 0.4m will be conveyed from the scene of the call	London Ambulance Service; QSurveillance; NPPS
1% will require hospitalisation	Roughly 0.2m will require hospitalisation	SPI-M pandemic planning profiles

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Overview of presentation

Exam questions we are interested in

- Methodology used to answer questions
- Headline figures produced from the model
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- Links to other work
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Exam questions

- **General epidemiology of the pandemic**
 - When will week 1 of the pandemic flu hit?
 - What is the profile of the pandemic?
 - > How long will the pandemic last?
 - > How many people will have flu-like symptoms in each week of the pandemic (i.e. number of clinical cases)?
 - What is the current status of the pandemic?
- **Demand for ambulance services during a pandemic**
 - What is the conversion factor from clinical cases to ambulance activity?
 - > How many of the clinical cases will call 999 for an ambulance?
 - > How many of these 999 calls will require a response at the scene?
 - > How many of these responses will require a conveyance from the scene?
 - During a pandemic, what will the profile of demand look like for ambulance services?
 - > i.e. how many calls/incidents/conveyances should we expect in each week of the pandemic?
 - What is the level of demand (calls/incidents/conveyances) we should expect in the peak week of the pandemic?

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General epidemiology of the pandemic

- When will week 1 of the pandemic flu hit?
 - Unclear, but possibly when schools/unl resume, or when weather turns colder
- How long will the pandemic last?
 - Current planning assumptions are for a 15 week attack profile with one peak
 - Future plans may include a longer cycle, with an initial smaller peak followed by a larger later peak
- How many people will contract flu in each week of the pandemic (i.e. number of clinical cases)?
 - See slides overleaf

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What is the scale of the problem?

- Swine flu is **more prevalent** but **less fatal** than seasonal flu
- Net effect is roughly twice as many deaths from swine flu compared to seasonal flu, prior to the introduction of vaccination for at risk groups

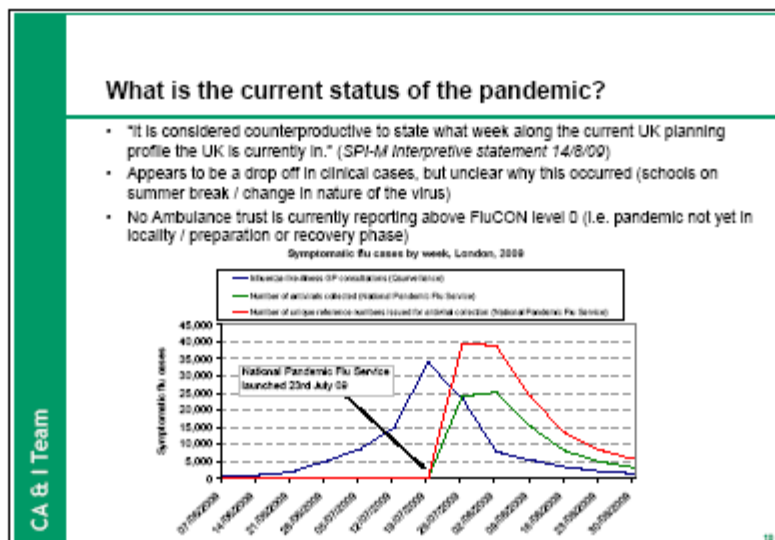
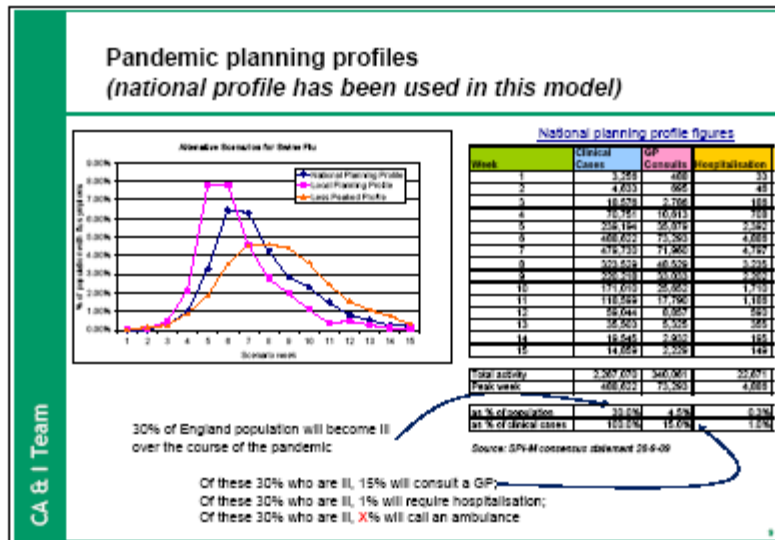
	Swine flu	Seasonal flu	Swine flu or Seasonal flu (some of these will have both)
% of clinical attack rate			
Case Fatality Ratio (deaths/infections *100)	0.10%	0.40%	
% of population affected			
Clinical attack Rate (infections/population *100)	30%	6%	
Deaths (deaths/population *100)	0.030%	0.024%	
Number of people affected			
Infections	15,300,000	3,000,000	17,400,000
Deaths	15,300	12,000	23,700

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Pandemic planning profiles (graphed on next slide)

- Provided by modelling sub-group of the Scientific Pandemic Influenza advisory committee (SPI-M) [DH, Health Protection Agency (HPA) Imperial College]
- Based on 1918 flu pandemic
 - 1957 & 1968 pandemics were not as severe as the 1918 Spanish Flu
- 3 different planning profiles – but advised to plan to local profile
 - NB. The peak in the national profile is lower than the peak in the local profile because aggregating data to the national level averages out local variations
- Planning assumptions are continually being reviewed and updated, for example, the hospitalisation rate has been revised from 2% of clinical cases to 1%
- Work underway for developing nowcasting & forecasting based on current pandemic information

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What is the current status of the pandemic?

- Drafting notes:
 - NPFS and GP consults are apples and pears, so how to aggregate information?
 - Use number of NPFS antiviral collections rather than URNs, as will provide better consistency with GP consults?
 - Try to add NPFS and GP consults, adjust for double counting if same person uses both services, then downweight NPFS contacts as using the NPFS website is easier than consulting a GP; it is likely that several assessments on the website equate to one GP consultation not taken i.e. 4 NPFS may equal one notional GP consult?
 - These are symptomatic cases, not lab-confirmed H1N1 cases. We do not know how many H1N1 cases there are for each case that has contacted a GP or NPFS.
 - Use HPA modelling figures reported by Chief Medical Officer? Some variance in estimates e.g. national weekly peak over summer of 100,000 cases is much lower than estimates from aggregating NPFS and QSurveillance data?

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To what extent will these clinical cases translate into ambulance activity?

- What data are available?
- Which methodology should we use to combine the available data?
- Caveats associated with assumptions

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Overview of presentation

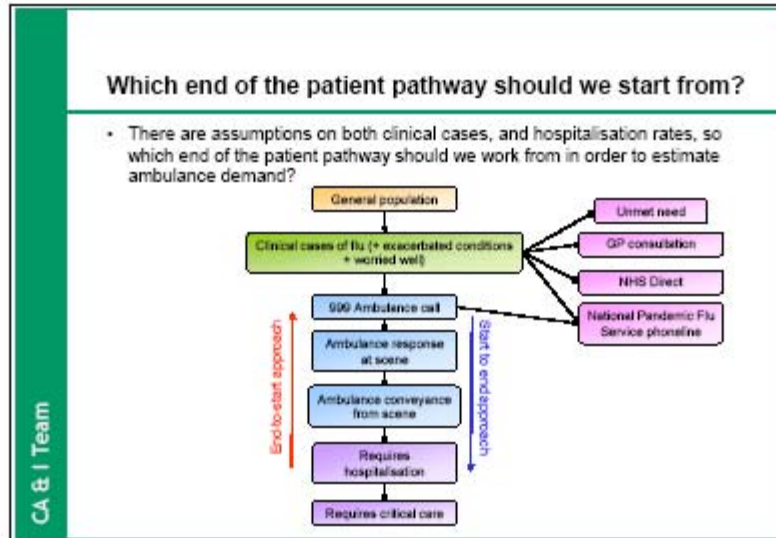
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What data are available?

Issue	Data source	Nature	Timeliness	Notes
Population denominators	CNS	Resident population estimates, SIA level	Annual	Not workplace/daytime population. Need to aggregated AMB trusts to SIA level
Number of clinical cases in current pandemic	CG surveillance reports	Flu consultation rates from a sample of GP practices	Daily	Launch of NPPS on 23 rd July 2009 will likely lower GP consult rate
	National Pandemic Flu Service (NPPS)	Unique reference numbers (URNs) issued for individuals	Daily	
Ambulance activity	Weekly Sitreps	Category A and B incidents, by AMB trust	Weekly	Cat C not reported
	London Ambulance Service (LAS)	Number of flu & severe flu related calls, incidents and conveyances, for Category A, B & C calls	Daily	Based on wild card hospital searches initially – no conveyance info Now reported on basis of Card 36 & include conveyances
	KACA publication	Call, incident, patient journey volumes by AMB trust	Annual, 2008/09 latest	

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“End-to-start” approach through the patient pathway

Work backwards from hospitalisation rates to estimate ambulance demand

Assumption	Data source for assumption	Illustrative numbers
1% of clinical cases require hospitalisation	National planning assumptions, GP-M Assume here that number admitted = number requiring hospitalisation	5,000 clinical cases, of which 50 (or 1%) will be admitted
Of these 1% of admitted cases, roughly half (54%) will be conveyed to A&E by ambulance	Experimental A&E HES Data, NHS IC, 2007/08 (N.S. Data for all general cases, not specifically for flu) (Of 2.5m sampled admits via A&E, 1.4m were conveyed by ambulances)	Of the 50 admissions, 27 will be conveyed to A&E by ambulance
Ambulances will also convey roughly one (1.05) non-admitted case to A&E for every conveyance that is admitted	Experimental A&E HES Data, NHS IC, 2007/08 (Of 2.9m sampled ambulance conveyances to A&E, 1.4m were admitted) N.S. does not include ambulance conveyances to places other than A&E e.g. stroke unit	In addition to the 27 conveyances that are admitted, there will be another 29 conveyances to A&E via ambulances which are not admitted. In total there will be 56 conveyances, which is only slightly higher than the number of 50 hospitalisations

Can assume that ambulance conveyances will be only slightly higher than hospitalisations. Then gross up conveyances into incidents, and gross up ambulance incidents into ambulance calls

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“Start-to-end” approach through the patient pathway

- Start with number of clinical cases and work down the pathway to determine how many of these will call 999 for an ambulance and require further ambulance services
- Determine
 - How many of the clinical cases will call 999 for an ambulance?
 - How many of these 999 calls will require a response at the scene?
 - How many of these responses will require a conveyance from the scene?

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Basic logic of the “Start-to-end” methodology we used

- 1) Determine conversion factor from clinical cases to ambulance activity
 - e.g. of 30% of England population who will be ill with flu, what % will call 999 for an ambulance?
 - Note this is a static conversion factor, but we should expect some variation (e.g. more people call 999 than expected at peak of activity, as NHS Direct, Flu Line and GP OOH become saturated – people will default to the service that says “Yes”)
- 2) Assume that ambulance activity will grow in proportion to the number of clinical cases
 - As clinical cases increase, ambulance calls will increase commensurately

– For illustration:

- So far there have been 100 clinical cases of swine flu
- Of these 100 cases, 15 consulted a GP, 8 called an ambulance, and 2 required hospitalisation (note that these may be 15 different individuals)
- If the planning profile suggests that next week there will be a doubling to 200 clinical cases, we would expect 16 of these to call an ambulance

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The ili parfait

- We want to model the number of calls/incidents/conveyances during the pandemic that are:
 - Swine-flu related i.e. Influenza-like-illness (ILI)
 - Exacerbated by swine flu
 - Baseline activity independent of ILI

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Modelling calls related to ili

Influenza-like illness (ILI) activity and ILI-related ambulance utilisation in London

Week	Number of clinical cases	ILI ambulance calls	Ambulance calls per clinical case
07/06/2009	797	42	5.3%
14/06/2009	1,006	57	5.7%
21/06/2009	1,855	116	6.3%
28/06/2009	5,040	288	5.7%
05/07/2009	8,433	610	7.2%
12/07/2009	14,754	698	4.7%
19/07/2009	33,896	1,239	3.7%
26/07/2009	47,753	1,180	2.5%
02/08/2009	33,064	2,613	7.9%
09/08/2009	20,648	2,760	13.4%
16/08/2009	11,497	1,629	14.2%
23/08/2009	7,155	1,104	15.4%
30/08/2009	4,824	729	15.1%
Total	180,722	19,066	6.8%

Clinical cases from Qsurveillance; Amb swine flu calls determined by free text searches of call descriptions

Clinical cases from Qsurveillance & NPFS; Amb swine flu calls determined by Card 36

Assume that **6.9%** of clinical cases will result in a 999 ambulance call

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Modelling calls related to ili

- From 07/08/09 to 30/08/09 there were 13,000 swine flu ambulance calls in London, and over this period there were 190,000 clinical cases symptomatic of flu
- Can assume from this ratio that 6.9% of clinical cases will result in a 999 ambulance call
- **However**, this ratio is very sensitive to changes in the numerator (swine flu amb calls) and denominator (clinical cases)
 - Numerator
 - If swine flu calls are recorded more accurately using Card 36 than by using free text searches, may expect that there will be more than 7 Amb calls per 100 clinical cases (numerator increases e.g. 8 calls per 100 cases), as Card 36 figures are generally higher
 - Denominator
 - If we use NPPS URNs rather than antiviral collections as our measure of clinical cases, then will expect less than 7 Amb calls per 100 clinical cases (denominator increases e.g. 7 calls per 100 clinical cases)
 - If we use HPA adjustment for aggregating NPPS and QISurveillance data then may expect increase in number of amb calls per clinical case (i.e. denominator decreases e.g. 7 calls per 90 clinical cases)

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Key conversion ratios for ili ambulance activity

- Assume static conversion ratios (based on LAS data)
 - Of the 30% of clinical cases, 6.9% will result in an ili ambulance call (i.e. 6.9% of the 30%)
 - 58% of these ili ambulance calls will result in an ili ambulance incident (i.e. 58% of the 6.9%)
 - 62% of these ili ambulance incidents will result in an ili ambulance conveyance (i.e. 62% of the 58%) [n.b. supply constraints will start to bite on conveyances first; easier to obtain extra call handlers than extra amb vehicles/paramedics]

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Modelling baseline activity

- Carry forward the average of category A & B incidents (**weekly SitReps**) from the weeks prior to the sharp increase in London ill cases
 - i.e. the weeks of pre-flu "normal" average activity
- For example, from w/e 6/4/09 to 31/05/09 the weekly average of Cat A&B incidents in weeks with little flu activity was **14,853**
- Baseline of the parfait is therefore a constant 14,853 (or **20,302** including Cat C – see next slide) incidents
 - This is the average level of activity we would expect in the absence of a pandemic
 - Any ill activity (whether primary ill, or exacerbated by ill) is the "froth" on top

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Converting from SitRep Cat A&B data to Cat A,B,C data; Converting from calls to incidents to conveyances

- Need to gross up A&B SitRep data to include Cat C activity (using **KA34** proportions)
 - Assume that Cat A&B incidents account for **73%** of all A,B&C incidents
 - For example, gross up baseline Cat A&B incidents from **14,853** to baseline of Cat A&B&C incidents of **20,302**
 - Baseline of the parfait is therefore a constant **20,302** A,B,C incidents
 - (Cat C weekly data would be more helpful)
- Also need to convert these incidents into calls or conveyances by using Trust-level KA34 annual proportions e.g. expect **30,698** baseline 999 Cat A,B&C ambulance calls for London Ambulance Service

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Modelling activity exacerbated by ili

- Subtract ili-related incidents from all incidents during the infection period; remaining incidents are "not primarily affect by swine flu incidents"
- Compare this *actual* number of non-ili incidents to the number we would *expect* from baseline of 20,302 incidents per week
 - Can also derive alternate counterfactual of expected number of incidents in each week of 2009/10 by applying growth rate from 2007/08 to 2008/09 to the 2008/09 figures i.e. carry forward last year's growth
 - Can also use trusts' own estimates of baseline activity
- The extra calls over and above the baseline is assumed to be activity that is affected/exacerbated by swine flu e.g. worried well, exacerbated asthma

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Modelling activity exacerbated by ili

- Relate extra calls over and above baseline to the number of clinical cases over the period
- Assume that 1% of clinical cases will result in **exacerbated 999 incidents**
- **HOWEVER** this assumption may overegg the pudding
 - Calls over baseline might be due to non-flu fluctuation in calls (e.g. Wimbledon/heatwave/random variation)
 - Need a purer cut of those calls that are likely to be exacerbated by swine flu (e.g. AMPDS codes referred to in data request in final slide), rather than having a broad "not primarily affected by swine flu" category

Rationale for ambulance incidents possibly exacerbated by ili	
245,396	Actual number of non-ili incidents during the infection period
20,450	per week
243,621	Expected number of non-ili incidents during the infection period
20,302	per week
1,775	Extra non-ili activity over ili period
185,898	Number of clinical cases over ili period
1%	Ratio of extra non-ili activity to clinical cases

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16% will consult a GP	Roughly 2.3m will consult a GP	SPI-M pandemic planning profiles
6.9% will call an ambulance	Roughly 1.1m will call 999 for an ambulance	London Ambulance Service; QISurveillance; NPPS
4.0% will receive an emergency response at the scene	Roughly 0.6m will receive an emergency response at the scene of the call to 999	London Ambulance Service; QISurveillance; NPPS
2.6% will require a conveyance from the scene	Roughly 0.4m will be conveyed from the scene of the call	London Ambulance Service; QISurveillance; NPPS
1% will require hospitalisation	Roughly 0.2m will require hospitalisation	SPI-M pandemic planning profiles

London Ambulance Service NHS Trust
Winter and Flu Planning Framework 2009/10

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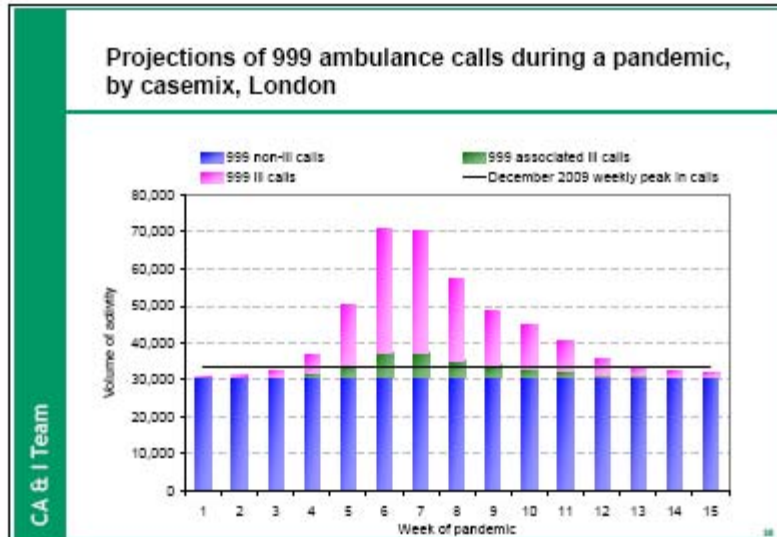
The ili parfait for London

- We want to model the number of calls/incidents/conveyances during the pandemic that are:
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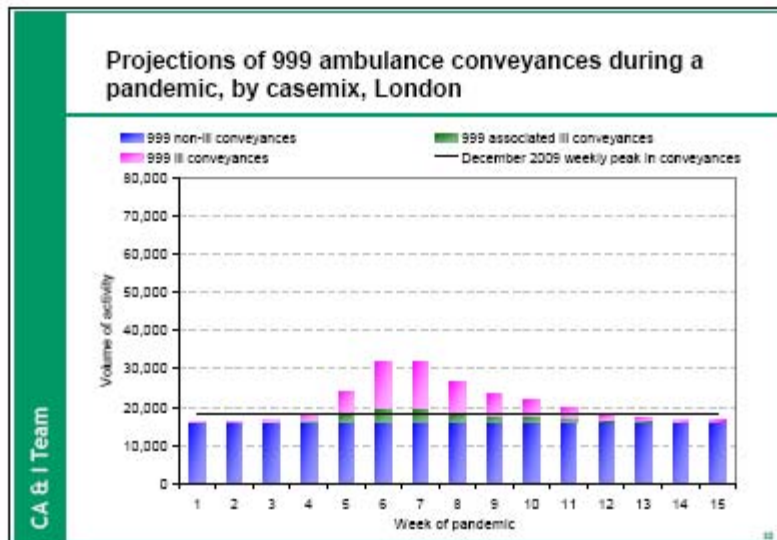
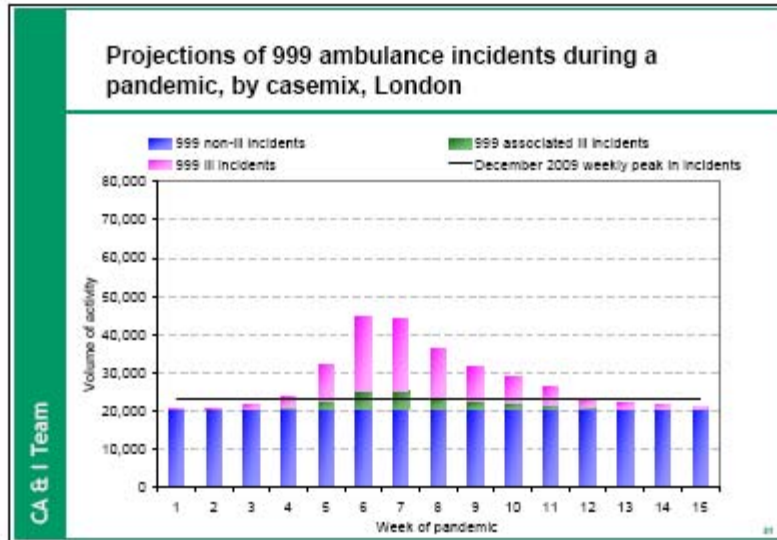
Total Ambulance activity during a pandemic

- Assume that 8.8% of clinical cases will be result in an ili-related ambulance call
- Assume that 1.0% of clinical cases will result in an ambulance call for conditions exacerbated by ILI (e.g. calls for chest pain, breathing problems, after ILI calls have been excluded)
- Assume 30,000 calls as ongoing baseline activity

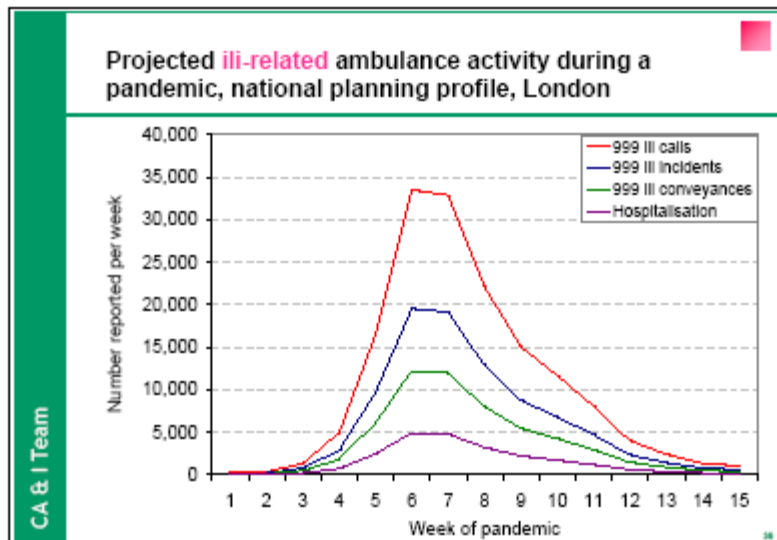
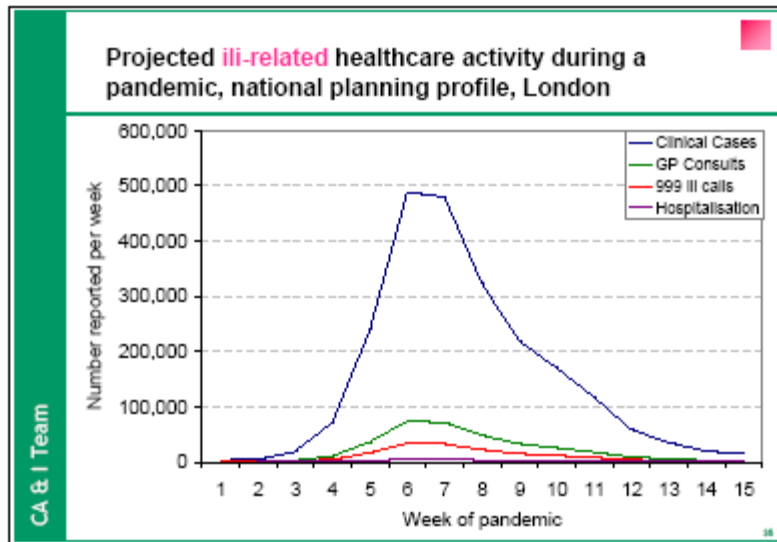
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Next steps to improve model

- Validate assumptions with other ambulance trust data
 - London conveyance for all incidents is generally much lower than other ambulance services
 - Non-ill baseline activity and ill-exacerbated activity are particularly important to model correctly
- Obtain a purer cut of those calls that are likely to be exacerbated by swine flu (e.g. AMPDS codes referred to in data request in final slide), rather than having gross "not primarily affected by swine flu" category
 - This may reduce the variance between conveyance rate of 2.5% of clinical cases, and hospitalisation rate of 1% of clinical cases (though note that not all conveyances go to A&E, not all conveyances are hospitalised, and not all hospitalisations are brought in by ambulances)
- Need more data from trusts – please see attached proforma
- Turn into monitoring tool for individual trusts to see where they are in various stages of the pandemic
- DN: Look at AMB activity over past seasonal flu outbreaks

**London Ambulance Service NHS Trust
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Activity data needed for each Ambulance Trust

		ISS All ISS calls from 0000 to 2359 prior to Call 99 activation						ISS All ISS calls for Breathing, Sick Person, Child/Pat, Medical conditions					
Financial Year	Week ending	Classified as Home P/A			Classified as P/A			Home P/A with State A			All Other AMPDS codes		
		ISS Calls	Conversations	Incidents	ISS Calls	Conversations	Incidents	ISS Calls	Conversations	Incidents	ISS Calls	Conversations	Incidents
DEMAND	6/20/09												
DEMAND	6/28/09												
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Links to other work

- Model extra inflows from NHSD, NPFS & NPFS as they reach saturation and patients default to 999 [most likely in peak weeks]
- Model effect of outflows from ambulance service; as A&Es become stacked up there will be delayed handovers which will have knock on effect on ambulance capacity to meet rising inflowing demand
- As well as modelling new cases each week, include impact of accumulation of a stock of cases in hospital with possibly long lengths of stay
- Model behavioural change if patients stop self-presenting if they expect long waits for ambulance or A&E

```
graph LR; A["NPFS  
NHS Direct  
GP OOH"] --> B["Ambulance  
activity"]; B --> C["A&E  
attendances"]
```

- Use projected ambulance demand as inputs into ORH Ltd. models of effect of increased demand and reduced supply (e.g. staff sickness) on performance against ambulance response time operational standards
- What is the integrity of the 999 phone system to cope with this demand?

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Appendix C

Managing Excess Demand: Stages 1 to 3

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LONDON AMBULANCE SERVICE – EMERGENCY OPERATIONS CENTRE

MANAGING EXCESS DEMAND PLAN

STAGE 1

INSTRUCTIONS FOR CALL TAKERS

Take all 999 emergency calls as normal, fully completing:

- Case entry
- Chief complaint
- Key questions

Once you have completed all key questions check the MPDS priority level (on the bottom of the ProQA screen) if the call is either **an ALPHA (A) or an OMEGA (Ω)**, give the relevant PDIs for the selected protocol and then give the following statement:

“Unfortunately, due to (*Specify the reason*) we may not be able to send you an ambulance.

One of our Clinical Telephone Advisors (CTA) will need to ring you back, so please stay by the phone/keep your mobile switched on.

I need to hang up now to take another call, but if s/he gets worse in any way, call back immediately for further instructions.”

The call should be completed in the usual manner.

LONDON AMBULANCE SERVICE – EMERGENCY OPERATIONS CENTRE

MANAGING EXCESS DEMAND PLAN

STAGE 1

INSTRUCTIONS FOR SECTOR DESKS

Do not dispatch a vehicle to any calls that are coded ALPHA (A) or OMEGA (Ω).

If you have already dispatched a vehicle to a call that becomes an **ALPHA (A)** or an **OMEGA (Ω)**, then cancel down the crew.

ALPHA (A) or OMEGA (Ω) callers will be told that an ambulance may not be sent and that CTA/CSD will ring them back.

Do not dispatch a vehicle to any AS3 calls as alternative arrangements will be made to deal with these.

LONDON AMBULANCE SERVICE – URGENT CARE SERVICE

MANAGING EXCESS DEMAND PLAN

STAGE 1

INSTRUCTIONS FOR CTA/CSD STAFF

CTA or CSD should ring back all **ALPHA (A)** or **OMEGA (Ω)** calls only and carry out a simple ABC check.

ALPHA (A) or **OMEGA (Ω)** callers will be told that initially an ambulance will not be sent.

If it is impossible for the patient's condition to be managed without an ambulance response, then the call should be returned to the sector desk. The AS1 held by the sector should have the '**AMBER 2**' watermark overwritten with '**AMBER 1**'.

Send on any calls where there is NO contact on ring back.

LONDON AMBULANCE SERVICE – EMERGENCY OPERATIONS CENTRE

MANAGING EXCESS DEMAND PLAN

STAGE 1

INSTRUCTIONS FOR EOC MANAGERS

THIS PROCEDURE WILL ONLY BE IMPLEMENTED ON THE AUTHORITY OF GOLD

1. Record start time of Stage One in the Occurrence Book (OB)
2. **Issue the Stage One EOC Action Cards to all call handlers.** Calls categorised as **ALPHA (A)** or **OMEGA (Ω)** will be called back by CTA/CSD and may not get an LAS response.
3. **Issue the Stage One EOC Action Cards to all sector staff.** Calls categorised as **ALPHA (A)** or **OMEGA (Ω)** will be called back by CTA/CSD and may not get an LAS response
4. **Issue Stage One CTA/CSD Action Cards to all CTA/CSD staff.** Calls categorised as **ALPHA (A)** or **OMEGA (Ω)** will be called back by CTA/CSD and a simply ABC check will be carried out.
5. EOC Officers should be tasked to walk the Call Taking floor in order to intervene during calls where the Call Handler is experiencing difficulty in terminating a call.

6. Additional resources that become available (i.e. Station Officers/Team Leaders etc.) and who contact EOC will be asked to contact their resource centre. If the resource centre is closed, they should make themselves available to their sector desk.
7. **Instruction is to be given that when an abandoned call is received, it will not be rung back.**
8. Ambulances should not be sent to AS3 calls. When practical these should be rung back and informed of the situation and instructed to make their own arrangements for the duration of the Incident.
Ideally this should be dealt with by staff other than core EOC staff (i.e. HQ Admin etc)
9. **Implementation of this procedure will release 50 vehicles from normal operational duties.**
10. Extending this procedure to **STAGE 2** can only be done on the authorisation of **GOLD**.
11. If at any time a Call Handler feels it is unsafe to leave a child/elderly person on their own, a patient in the street/public place or if the patient is alone or infirm, complete the call as normal and CTA/CSD will manage the call accordingly.

LONDON AMBULANCE SERVICE – URGENT CARE SERVICE

MANAGING EXCESS DEMAND PLAN

STAGE 1

INSTRUCTIONS FOR URGENT CARE

**THIS PROCEDURE WILL ONLY BE IMPLEMENTED
ON THE AUTHORITY OF GOLD**

1. Do not dispatch a vehicle to any **ALPHA (A)** or **OMEGA (Ω)**, URGENT or **NON-URGENT** calls.
2. On the instruction of Gold, if you have already dispatched a vehicle and it is on route to a call that is **ALPHA (A)** or **OMEGA (Ω)**, URGENT or **NON URGENT**, then cancel the crew down.
3. If a major incident Staff to undertake duties as specified in the Urgent Care Major Incident Grab Pack
4. CTA will instigate their responsibilities as specified within the Extreme Over Capacity Plan
5. CSD will instigate their responsibilities as specified within the Extreme Over Capacity Plan
6. Patient Transport Services to be utilised as per demand or need

LONDON AMBULANCE SERVICE – EMERGENCY OPERATIONS CENTRE

MANAGING EXCESS DEMAND PLAN

STAGE 2

INSTRUCTIONS FOR CALL TAKERS

Take all 999 emergency calls as normal, fully completing:

- Case entry
- Chief complaint
- Key questions

Once you have answered all the key questions, check the priority level (Bottom of the ProQA screen and top left corner of the AS1 screen).

If the call is an **MPDS OMEGA (Ω)** give the following statement in place of PDI's:

“Unfortunately, due to (*specify the reason*), we do not have an ambulance to send.

Our advice is to contact a GP or call NHS Direct or make your own way to a Minor Injuries Unit or to an Accident and Emergency Department.

I need to hang up now to take another call But if s/he gets worse in any way, call back immediately for further instructions.”

The call should then be quit, with the reason entered as **“NO SEND”**.

If the call is an MPDS ALPHA or CTAK AMBER 2, PTO...

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If the call is an MPDS **ALPHA** or CTAK **AMBER 2**,

“Unfortunately, due to *(Specify the reason)* we may not be able to send you an ambulance.

One of our Clinical Advisors will need to ring you back, so please stay by the phone/keep your mobile switched on.

I need to hang up now to take another call, but if s/he gets worse in any way, call back immediately for further instructions.”

The call should be completed in the usual manner.

If at any time a Call Handler feels it is unsafe to leave a child/elderly person on their own, a patient in the street/public place or if the patient is alone or infirm, complete the call as normal and CTA/CSD will manage the call accordingly.

Callers who want details about the suggested alternatives should be advised to **“NHSD”**

NHSD no is 0845 46 47.

LONDON AMBULANCE SERVICE – EMERGENCY OPERATIONS CENTRE

MANAGING EXCESS DEMAND PLAN

STAGE 2

INSTRUCTIONS FOR SECTOR DESKS

Do not dispatch a vehicle to MPDS OMEGA (Ω) or ALPHA or CTAK AMBER 2 calls.

If you have already dispatched a vehicle to a call that becomes **MPDS OMEGA (Ω) or ALPHA or CTAK AMBER 2 call** then cancel the crew.

MPDS OMEGA (Ω) callers will be told that an ambulance will not be sent.

ALPHA or CTAK AMBER 2 calls will be handled by CTA/CSD

Do not dispatch a vehicle to AS3 calls as alternative arrangements will be made to deal with these.

If at any time a Call Handler feels it is unsafe to leave a child/elderly person on their own, a patient in the street/public place or if the patient is alone or infirm, complete the call as normal and CTA/CSD will manage the call accordingly.

LONDON AMBULANCE SERVICE – URGENT CARE SERVICE

MANAGING EXCESS DEMAND PLAN

STAGE 2

INSTRUCTIONS FOR CTA/CSD STAFF

CTA/CSD should be provided for **MPDS ALPHA** or **CTAK AMBER 2 calls** only.

MPDS OMEGA (Ω) callers will be told that an ambulance will not be sent.

If it is impossible for the patient's condition to be managed without an ambulance response, then the call should be returned to the sector desk. The AS1 held by the sector should have the watermark overwritten with **AMBER 1**.

Calls where No Contact is made should be recorded as No send.

If at any time a Call Handler feels it is unsafe to leave a child/elderly person on their own, a patient in the street/public place or if the patient is alone or infirm, complete the call as normal and CTA/CSD will manage the call accordingly.

LONDON AMBULANCE SERVICE – EMERGENCY OPERATIONS MANAGER

MANAGING EXCESS DEMAND PLAN

STAGE 2

GUIDELINES FOR EOC MANAGERS

THIS PROCEDURE WILL ONLY BE IMPLEMENTED ON THE AUTHORITY OF GOLD

1. Record start time of Stage Two in the Occurrence Book
2. Issue the **Stage Two EOC Action Cards** to all call handlers. Calls categorised as **MPDS OMEGA (Ω)** will **NOT** be considered for an LAS response.
3. Issue the **Stage Two EOC Action Cards** to all sector staff. Calls categorised as **MPDS OMEGA (Ω)** will **NOT** be considered for an LAS response.
4. Issue Stage Two CTA Action Cards to all CTA/CSD staff. Calls categorised as **ALPHA** or **CTAK AMBER 2 calls**.
5. EOC Managers should be tasked to walk the Call Taking floor in order to intervene during calls where the Call Handler is experiencing difficulty in terminating a call.

6. Additional resources that become available (I.E. Station Officers/Team Leaders etc.) and who contact EOC will be asked to contact their resource centre. If the resource centre is closed, they should make themselves available to their sector desk.
7. Instruction is to be given that when an abandoned call is received; it will not be rung back.
8. Ambulances should not be sent to AS3 calls unless after a ring back a definite need is determined. When practical these should be rung back and informed of the situation and instructed to make their own arrangements for the duration of the Incident. Ideally this should be dealt with by staff other than core EOC staff (i.e. HQ Admin etc)
9. Implementation of this procedure will release an additional 25 vehicles from normal operational duties.
10. Extending this procedure to **STAGE 3** can only be done on the authorisation of **GOLD**.
11. 999 Call taking/CTA/CSD and Dispatch is that caution should be employed when the call indicates a child on their own, the elderly on their own, callers in the street, public places, if the caller is alone and the infirm.

LONDON AMBULANCE SERVICE – URGENT CARE SERVICE

MANAGING EXCESS DEMAND PLAN

STAGE 2

GUIDELINES FOR Urgent Care DESK

THIS PROCEDURE WILL ONLY BE IMPLEMENTED ON THE AUTHORITY OF GOLD

1. Do not dispatch a vehicle to any **MPDS ALPHA (A)** or **OMEGA (Ω)** or **Amber 2**.
2. On the authority of Gold, if you have already dispatch a vehicle on route to a call that is **ALPHA (A)** or **OMEGA (Ω)**, or **Amber 2**, and **URGENT** or **NON URGENT**, then cancel the crew down.
3. Staff to undertake duties as specified in the Urgent Care Major Incident Grab Pack
4. CTA will instigate their responsibilities as specified within the Extreme Over Capacity Plan
5. CSD will instigate their responsibilities as specified within the Extreme Over Capacity Plan
6. Patient Transport Services to be utilised as per demand or need

LONDON AMBULANCE SERVICE – Emergency Operations Centre

MANAGING EXCESS DEMAND PLAN

STAGE 3

INSTRUCTIONS FOR CALL TAKERS

Take all 999 emergency calls as normal, fully completing the:

- Case entry
- Chief complaint
- Key questions

Once you have answered the last key question, check the priority level (top left corner of the AS1 screen). If the call is either **or MPDS ALPHA (A) or OMEGA (Ω)**, give the following statement in place of PDIs:

“Unfortunately, due to a (*Specify Reason*), we do not have an ambulance to send.

Our advice is to contact a GP or NHS Direct or alternatively make your own way to an Accident and Emergency Department.

I need to hang up now to take another call, But if s/he gets worse in any way, call back immediately for further instructions.”

The call should then be quit, with the reason entered as **“NO SEND”**.

If at any time a Call Handler feels it is unsafe to leave a child/elderly person on their own, a patient in the street/public place or if the patient is alone or infirm, complete the call as normal and CTA/CSD will manage the call accordingly.

Callers who want details about the suggested alternatives should be advised to **“NHSD”**

LONDON AMBULANCE SERVICE – Emergency Operations Centre

MANAGING EXCESS DEMAND PLAN

STAGE 3

INSTRUCTIONS FOR SECTOR DESKS

Do not dispatch a vehicle to CTAK RED 3 or AMBER 1 or AMBER 2 or MPDS ALPHA (A) or OMEGA (Ω) calls.

If you have already dispatched a vehicle to a call that becomes **RED 3 or AMBER 1 or AMBER 2 or ALPHA (A) or OMEGA (Ω)**, then cancel the crew.

AMBER 1 and **AMBER 2** calls will be handled by Clinical Telephone Advice (CTA) and Clinical Support Desk (CSD)

RED 3 calls will be handled by Clinical Telephone Advice (CTA) and Clinical Support Desk (CSD)

Do not dispatch a vehicle to AS3 calls as alternative arrangements will be made to deal with these.

Call handlers have been told that if at any time they feel it is unsafe to leave a child/elderly person on their own, a patient in the street/public place or if the patient is alone or infirm, complete the call as normal and CTA/CSD will manage the call accordingly.

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STAGE 3

INSTRUCTIONS FOR CTA/CSD STAFF

CTA/CSD should be provided for **AMBER 1** and **AMBER 2** and **RED 3** calls only.

ALPHA (A) and OMEGA (Ω) callers will be told, by the call takers, that an ambulance will not be sent.

If it is impossible for the patient's condition to be managed without an ambulance response, then the call should be returned to the sector desk. The AS1 held by the sector should have the '**RED 3**' watermark overwritten with '**RED 2**'.

Call handlers have been told that if at any time they feel it is unsafe to leave a child/elderly person on their own, a patient in the street/public place or if the patient is alone or infirm, complete the call as normal and CTA/CSD will manage the call accordingly

No Contact will be recorded as No Send.

LONDON AMBULANCE SERVICE – Emergency Operations Centre

MANAGING EXCESS DEMAND PLAN

STAGE 3

INSTRUCTIONS FOR EOC MANAGERS

THIS PROCEDURE WILL ONLY BE IMPLEMENTED ON THE AUTHORITY OF GOLD

1. Record start time of Stage Three in the Occurrence Book
2. **Issue the Stage Three EOC Action Cards to all Call handlers.** Calls categorised as **ALPHA (A)** or **OMEGA (Ω)** will **NOT** be considered for an LAS response.
3. **Issue the Stage Three EOC Action Cards to all sector staff.** Calls categorised as **ALPHA (A)** or **OMEGA (Ω)** will **NOT** be considered for an LAS response.
4. **Issue Stage Three CTA/CSD Action Cards to all CTA/CSD staff.** Calls categorised as **AMBER 1** and **AMBER 2** and **RED 3** will be contacted by a Clinical Telephone Advisor and Clinical Support Desk.
5. EOC Managers should be tasked to walk the Call Taking floor in order to intervene during calls where the Call Handler is experiencing difficulty in terminating a call.

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6. Additional resources that become available (i.e. Station Officers/Team Leaders etc.) and who contact EOC will be asked to contact their resource centre. If the resource centre is closed, they should make themselves available to their sector desk.
7. Instruction is to be given that when an abandoned call is received, it will not be rung back.
8. Ambulances should not be sent to AS3 calls. When practical these should be rung back and informed of the situation and instructed to make their own arrangements for the duration of the Incident. Ideally this should be dealt with by staff other than core EOC staff (i.e. HQ Admin etc)
9. Implementation of this procedure will release an additional 25 vehicles from normal operational duties.
10. If at any time a Call Handler feels it is unsafe to leave a child/elderly person on their own, a patient in the street/public place or if the patient is alone or infirm, complete the call as normal and CTA/CSD will manage the call accordingly.

LONDON AMBULANCE SERVICE – URGENT CARE SERVICE

MANAGING EXCESS DEMAND PLAN

STAGE 3

INSTRUCTIONS FOR Urgent Care DESK

THIS PROCEDURE WILL ONLY BE IMPLEMENTED ON THE AUTHORITY OF GOLD

1. Do not dispatch a vehicle to any **ALPHA (A)** or **OMEGA (Ω)**, **Amber 1**, **Amber 2** and **Red 3**, and **URGENT** or **NON-URGENT** calls.
2. On the instruction of Gold, if you have already dispatch a vehicle on route to a call that is **ALPHA (A)** or **OMEGA (Ω)**, **Amber 1**, **Amber 2** and **Red 3**, and **URGENT** or **NON URGENT**, then cancel the crew down.
3. Staff to undertake duties as specified in the Urgent Care Major Incident Grab Pack
4. CTA will instigate their responsibilities as specified within the Extreme Over Capacity Plan
5. CSD will instigate their responsibilities as specified within the Extreme Over Capacity Plan
6. Patient Transport Services to be utilised as per demand or need

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Appendix D

National Memorandum of Understanding (MOU) Regarding Mutual Aid

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UK Ambulance Services

National Memorandum of Understanding Concerning the Provision of Mutual Aid

Plan Author	General Manager Operations Support EMAS/Deputy CEO LAS
Date and version	July 2009 Version 2.4
Plan Supports	Ambulance Services' Major Incident Plans
Circulation	Chief Executives Directors of Operations Emergency Planning Leads
Review Date	Post Incident / Annually

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1. Background

- 1.1 This national mutual aid Memorandum of Understanding (MOU) provides a framework through which UK Ambulance Services can jointly agree to provide mutual assistance on a national scale, including devolved administrations in the event of a major incident¹, terrorist attack, pre-planned mutual aid such as G20, Olympics. Mutual Aid is defined as “An agreement between responders, within the same sector or across sectors and across boundaries to provide assistance with the additional resources during an emergency which may go beyond the resources of an individual respondent.”
- 1.2 It is recognized that a major or catastrophic Incident may place enormous demands on an Ambulance Service, particularly in situations which result in mass casualties. This MOU therefore is intended to complement and extend current local arrangements, ensuring that NHS Ambulance Trusts and devolved administrations have access to appropriate resources should a major or catastrophic Incident occur in their area. It provides a basis for the obligatory provision of mutual aid between services in the event of a major or catastrophic incident and any pre-planned mutual aid.
- 1.3 All Ambulance Services must be in a position to respond to a major or catastrophic incident within its own operational area. Within the same arrangements Ambulance Services must be capable of providing support to other Ambulance Services in a structured and progressive way.
- 1.4 This Memorandum of Understanding (MOU) is agreed between all ambulance services on the UK mainland and also includes the devolved administrations of Northern Ireland, Scotland and Wales. Support to the Channel Isles and the Isle of Man will be subject to separate arrangements.

2. Purpose

- 2.1 The purpose of this MOU is to assist NHS Ambulance Trusts including devolved administrations in providing the organisational capability, capacity and structure to enable the delivery of a coordinated national response to a range of major or catastrophic incidents and any pre-planned mutual aid.

3. Objectives

¹ The NHS Emergency Planning Guidance 2005
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3.1 The objective of this MOU is to reach an agreement from all parties which would enable the deployment of a range of staff, vehicles and specialised equipment and assets to the affected Ambulance Trust including devolved administrations for use in a pre-planned event or major or catastrophic incident, for example a terrorist attack, CBRN or natural disaster on a local, regional or national scale.

3.2 The objective of this mutual aid agreement is therefore to establish an agreed framework for:

‘The request of mutual aid by any NHS Ambulance Trusts, including devolved administrations in response to a major or catastrophic incident or pre-planned event’

4. Criteria for implementation

4.1 The primary criteria for implementing mutual aid arrangements are:

When the requesting NHS Ambulance Trust or devolved administration is potentially or actually unable to maintain safe level of critical services either through lack of material or human resources.

4.2 It is likely though not mandatory that the requesting NHS Ambulance Trust would have reached Reap Level 5 Potential Service Failure and would also have declared an internal major Incident.

5. Authority and Responsibility

5.1 In the event of a major or catastrophic incident or pre-planned events the affected service or devolved administration will have the responsibility to request resources from other Services. It follows therefore that any Service receiving such a request will, where possible, supply mutual aid on request, subject to the maintenance of a safe level of service delivery within its own area.

5.2 “the affected service” means an Ambulance Trust or devolved administration is potentially or actually unable to a maintain a safe level of critical services either through lack of material or human resources.

5.3 “area” means the geographical area for which an Ambulance Trust or devolved administration is responsible.

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5.4 “assisting UK Ambulance Service ” means a UK Ambulance Service providing assistance in accordance with this MOU.

5.5 “Primacy” The Host Ambulance Service will have primacy at the scene and all resources deployed in pursuance of mutual aid will at all times act under the command and control of that Ambulance Service.

6. Resources

6.1 Within this MOU resources are defined as the human and material resources which, when the request for assistance is received, it is reasonably practicable for an Ambulance Service to make available to an affected Ambulance Service. This should be consistent with the discharge of its statutory duties, including resources which can be reasonably made available by changes to the arrangements for dealing with normal requirements. Resource may be:

- People
- Vehicles
- Equipment (medical and communications)
- Consumable medical and surgical supplies
- Specialist resources as necessary

7. Provision of Available Resources

7.1 In the event of a Chief Executive or Nominated Officer of an affected Ambulance Service requesting assistance under this agreement, each Ambulance Service agrees to provide assistance in the form of:

- The mobilisation, attendance, deployment and use of such of its available resources as are requested to deal with the major or catastrophic incident or pre-planned event.
- The deployment of such of its available resources as are requested to such locations in the affected Ambulance Services area as may be agreed in order to provide cover for other major or catastrophic incidents or pre-planned events within the affected Ambulance Service’s area.
- The attendance of such of its available senior officer resources as are requested to assist the command, control or deployment of ambulance resources for the purpose of any incident within the affected Ambulance Service’s area.

7.2 The extent of assistance to be provided by the assisting Ambulance Service will be agreed by their Chief Executive or Nominated Officer at the time of the request and

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where necessary reviewed in the light of changed circumstances as the major or catastrophic incident or pre-planned event develops and local circumstances change.

- 7.3 In the event of an Ambulance Service requiring the implementation of mutual aid the initial activation process will be either through the National Ambulance Coordinating Centre (NACC if it is Operational at the time) or through a National Operations Directors Group (NDOG) conference call. The Operations Director of the affected ambulance service should contact the current Chair of NDOG who will then initiate the conference call. All further communications will then be managed either by the NACC or by regular NDOG conference calls

8. Command and Control

- 8.1 The affected Ambulance Service will put in place appropriate Gold, Silver and Bronze command structure in accordance with their Major Incident plan Command and Control Structure. Services providing mutual aid will provide officers to join these teams as appropriate.

9. Form Up Point(s) (FUPs)

- 9.1 Each Ambulance Service has identified several FUP / RVP (appendix 1) within their operational areas based upon road networks and likely risk sites. These inevitably may be subject to change based on the circumstances of each particular incident or scenario.
- 9.2 The Ambulance Service requesting mutual aid will nominate FUP(s) to which all Mutual Aid resources will be deployed in the first instance to be held there prior to deployment as on the instructions of the affected Ambulance Service. Each Service will nominate an officer to manage the arrangements at the FUP/RVP.

10. Communications and Media

- 6.1 Primary incident communications and media management will be under the direction of the affected Ambulance Service.

11. Welfare

- 11.1 The affected Ambulance Service shall ensure so far as reasonably practicable the health and safety of staff from an assisting Ambulance Service in the same satisfactory manner as those from the affected Ambulance Service (e.g. staff are only to be placed in situations for which they are properly trained and equipped).

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- 11.2 An affected Ambulance Service shall ensure that staff from an assisting Ambulance Service have their welfare needs met in the same satisfactory manner as those from the affected authority (e.g. securing adequate provision of food, drink and, where necessary, accommodation).
- 11.3 Risk assessments will take place by the affected Ambulance Service to mitigate and/or reduce any risks that are apparent to the staff from any service.

12. Mutual Aid Stand-down

- 12.1 The affected Ambulance Service will declare Mutual Aid Stand-down.

13. Costs

- 13.1 As The principle of 'shared risk' in the context of this agreement, recognises the fact that the risk of a major incident or pre-planned event occurring, which results in the need for mutual aid, is equal amongst all NHS organisations.
- 13.2 Any mutual aid provided by assisting Ambulance Trusts will be on the basis of 'shared risk' and costs lie where they fall. Consequently, there will no cross charging for mutual aid between Ambulance Trusts.
- 13.3 As part of the risk sharing agreement, the affected Ambulance Trust will collate all associated Mutual and Aid costs for audit purposes.
- 13.4 It is recognised that the level of resources, which NHS Ambulance Trusts are able to provide, will be governed by the resources that are available to it. To this extent the mutual aid provided will inevitably be time-limited and will be for discussion when an incident occurs.
- 13.5 If any Ambulance Service wishes to discuss associated costs of supplying extended mutual aid with the affected Ambulance Service then discussions may take place between the relevant finance directors once the major or catastrophic incident or pre-planned event has been stood down.

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14. Participants

14.1 The Ambulance Services participating and signed up to this MOU are:

South Western Ambulance Service NHS Trust
London Ambulance Service NHS Trust
South East Coast Ambulance Service NHS Trust
South Central Ambulance Service NHS Trust
Yorkshire Ambulance Service NHS Trust
Great Western Ambulance Service NHS Trust
East of England Ambulance Service NHS Trust
East Midlands Ambulance Service NHS Trust
West Midlands Ambulance Service NHS Trust
North East Ambulance Service NHS Trust
North West Ambulance Service NHS Trust
Isle of Wight Ambulance Service
Scottish Ambulance Service
Welsh Ambulance Service
Northern Ireland Ambulance Service

15. Status of MOU

15.1 This MOU is not legally binding on any Ambulance Service; it establishes the terms under which an Ambulance Service may expect to request assistance from or provide assistance to another Ambulance Service in the event of a serious incident.

16. Contact Details

16.1 Appendix 2 provides key contact details for each participating Ambulance Service.

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Form Up Points**

Ambulance Service	Location
Yorkshire	<ul style="list-style-type: none">• Junction of the A1 and A64 commonly known as Bramham Crossroads.• Junction with the A1 and A66 more commonly known as Scotch Corner.
South Central	<ul style="list-style-type: none">• Dynamic Risk assessment dependent upon the incident and location
North East	<ul style="list-style-type: none">• Dynamic Risk assessment dependent upon the incident and location
East Midlands	<ul style="list-style-type: none">• Gonerby Moor services, Grantham Lincolnshire NG32 2AB• Barney's Cafe Services, Scunthorpe North Lincolnshire DN15 6JP• Rothersthorpe Services, M1 – Banbury Lane, Northampton NN4 9CY• Watford Gap Services, M1 – Watford Gap Services, nr Watford Village, Northants NN6 7UZ• Leicester Forest East Services, M1 – Leicester Forest East Services – LE3 3GB• Trowel Services on the M1. Trowell , Nottingham NG9 3PL
South Western	<ul style="list-style-type: none">• Burnham Ambulance Station, Love Lane, Burnham on Sea, Somerset. TA8 1EU• Blandford Ambulance Station, 10a Sunrise Business Park, Blandford, Dorset. DT11 8ST• Clinical Hub (East), Ringwood Road, St Leonards, Nr Ringwood. BH24 2RR• Frome Ambulance Station, Unit 2 Georges Ground, Manor Trading Estate, Frome, Somerset. BA11 4RP• Glastonbury Ambulance Station, Beckery New Road, Glastonbury, Somerset. BA6 9NS• Shaftesbury Ambulance Station, 39-41 Bimport, Shaftesbury. Dorset, SP7 8AX• Shepton Mallet Ambulance Station, Board Cross, Shepton Mallet, Somerset. BA4 5DX• Wimborne Ambulance Station, Hanham Road, Wimborne, Dorset. BH21 1AS
South East Coast	<ul style="list-style-type: none">• Motorway Services, M25, Clackett Lane• Chertsey Make Ready Centre, Guildford Road,,Ottershaw. KT16 0PJ• Chichester Ambulance Station, Terminus Road, CHICHESTER, West Sussex, PO19 8TJ• Motorway Services, Pease Pottage, A23
North West	<ul style="list-style-type: none">• Dynamic Risk assessment dependent upon the incident and location
West Midlands	<ul style="list-style-type: none">• Dynamic Risk assessment dependent upon the incident and location
East of England	<ul style="list-style-type: none">• Dynamic Risk assessment dependent upon the incident and location
London	<ul style="list-style-type: none">• Dynamic Risk assessment dependent upon the incident and location

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Great Western	<ul style="list-style-type: none">• Strensham Services M5 South - between J7 and J8, WR8 9JL, 01684 290577• Michael wood Services M5 South - between J13 and J14, GL11 6DD, 01454 260631• Sedgemore Services M5 North - between J21 and J22, BS24 0JL, 01934 750888• Severn View Services M48 - J1, BS35 4BH, 01454 632851• Leigh Delamere Services M4 West - between J17 & J18, SN14 6LB, 01666 842015
Scottish Ambulance Service	<ul style="list-style-type: none">• Dynamic Risk assessment dependent upon the incident and location
Isle of Wight	<ul style="list-style-type: none">• Lay by at Grid Ref SZ524909 on A3054.
Welsh Ambulance Service	<ul style="list-style-type: none">• Dynamic Risk assessment dependent upon the incident and location

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Appendix 2

Directors of Operations and Emergency Preparedness Leads

Ambulance Service	Director of Operations	Emergency Preparedness Lead	Emergency Operations Centre
Yorkshire	Ian Walton 0192 458 4070	Mike Shanahan	0190 464 32258
South Central	Ian Ferguson: 0772 035 0375	John Dyer 0786 023 2340	0196 289 8239 0118 974 2562 0190 826 6082
North East	Paul Liversidge 0797 748 2788	Phil Bain 0797 066 9456	0191 414 3144 0190 464 3258
East Midlands	David Williams 0781 470 4871	Simon Harris 0787 567 5173	0115 967 0999
South Western	Tony James 0120 285 1650	Mike Killoran 0139 226 1626	0139 236 0414 0120 289 7697
South East Coast	Sue Harris 0789 989 2319	Andy Parr 0778 538 7360	0162 274 3089
North West	Bob Williams 0777 648 4533	Paul Kudray 0779 584 4912	0161 438 4159
West Midlands	Bob Ashford 0782 443 1763	Sue Wheatley 0777 418 7706	0138 421 5500
East of England	Neil Story 0160 342 4255	Robert Flute 0759 523 8698	0123 427 0050
London	Richard Webber 0778 557 3402	John Pooley 0777 855 2386	0207 827 4555
Great Western	Jonathen Lofthouse 0782 782 0542	Richard McKeand 0779 958 97894	0145 445 5431 0145 445 5433
Scottish Ambulance Service	Shirley Rodgers 0792 027 1868	Mike Herriot	0146 371 0567

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Isle of Wight	Dave Arnold 0791 226 7331	Keith Morey 0791 226 7336	0198 353 5632
Wales Ambulance Service	Steve Pryor 0789 193 8419	Cliff Randle	0162 725 5555
Northern Ireland Ambulance Service	Brian McNeill 0771 188 4286	William Newton 0776 776 0907	0289 040 4021
Crown Dependencies	John Sutherland 07797 728398	John Sutherland 07797 728398	0153 480 999

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Appendix E

National Coordinating Centre Data Template

**National Ambulance Coordinating Centre
Daily Information Template**

The following information should be returned on a daily basis by e-mail to the National Coordinating Centre (NCC) by 10.am.

A summary position for all UK trusts will then be compiled and returned to all Trusts by 12 am each day in preparation for the 13.00 conference call.

	LAS	SECA M	SCA S	SWA S	EOE	NEA S	NW AS	YAS	EMA S	WMA S	GW AS	IO W	Scotla nd	Wal es	N.Ireland
CAT A Activity % of Norm															
CAT B Activity % of Norm															
CAT C Activity % of Norm															
Overall Activity % of Norm															
AMB Availability % of Norm															
FRU Availability % of Norm															

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Fleet Availability % of Norm															
HART/USAR Availability % of Norm															
Control Room Availability % of Norm															
Hospital Turnaround Delays None/Moderate/Severe															
Absence Levels Field Ops % above Norm															
Absence Levels Control Rooms % above Norm															
Absence Levels Support Staff % above Norm															

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Essential Supply Chain Difficulties None/Moderate/Severe															
Requesting Mutual Aid Yes/No./Considering															
REAP LEVEL															

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Appendix F

Legal Advice Regarding HR Issues

Awaits release

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Appendix H

ORH Modelling Setting on Impact of Demand Rise and Staffing Shortfall

Awaits full release (some data utilised in framework document)

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Appendix I

DH Guidance on Infection Control for Ambulance Trusts

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Pandemic influenza

Guidance for ambulance services
and their staff in England



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Policy	Estates
HR/Workforce	Commissioning
Management	IM & T
Planning	Finance
Clinical	Social Care/Partnership Working
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Author	DH
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Cross reference	Pandemic flu: A national framework for responding to an influenza pandemic
Superseded documents	N/A
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For recipient's use	

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Pandemic influenza

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A strategic approach to pandemic influenza planning

Underpinning principles

In developing this guidance, the following underpinning principles have formed its basis:

- As far as possible, planning for an influenza pandemic should build on arrangements that are already in place rather than develop a series of new, 'special' arrangements. The approach required is to be able to use the usual mechanisms and procedures for deployment of ambulance trust resources in order to respond to an unusual set of circumstances.
- However, during the course of a pandemic there will be some crucial differences in how services will be delivered. These include:
 - building on the existing close links with local primary care trusts (PCTs) to prepare for and respond to a pandemic
 - building on the existing close links with local acute trusts and other healthcare providers to ensure a consistent approach to prepare for and respond to a pandemic
 - the basis for the treatment of patients with pandemic influenza, which will be treatment at home and advice on how, when and where to seek medical direction. Ambulance responses (both in control rooms and in the field) will need to reflect this change by having in place appropriate procedures and protocols to enable successful assessment and treatment at home
 - local flexibility for planning and responding, given the uncertainty about the effects of a pandemic.

This document does not provide detailed guidance on what a local plan for ambulance trusts should include, but rather a framework for local planning and links to resources that ambulance services may find useful. Individual services will need to draw up plans in partnership with the local health community and agree these with PCTs.

Background

Pandemic Influenza – what Is It?

Influenza pandemics are naturally occurring biological phenomena that have emerged from time to time throughout history. The conditions that allow a new virus to develop and spread continue to exist, and some features of modern society, such as air travel, could accelerate the rate of spread. Experts therefore agree that there is a high probability of another pandemic occurring, although timing and impact are impossible to predict.

An influenza pandemic occurs when a new or re-emerging influenza virus subtype emerges that is:

- markedly different from recently circulating strains
- able to infect people
- readily transmissible from person to person
- capable of causing illness in a high proportion of those infected
- able to spread widely because few – if any – people have natural or acquired immunity to it.

Whilst such a virus could first emerge anywhere in the world – including the UK – South East Asia, the Middle East or Africa are considered to be the most likely potential sources. Rapid spread would be likely to cause an epidemic within the country, which could become a pandemic if it spreads between countries.

More detailed information on influenza viruses, the illness they can cause and the impact of past pandemics is available at www.dh.gov.uk/pandemicflu

Planning assumptions and presumptions

The precise characteristics and impact of an influenza pandemic will only become apparent as the virus emerges. Therefore, some assumptions about a pandemic's course – and presumptions as to the UK's likely response in a number of key areas – are necessary to describe the impact the UK Government is currently planning for. Given the uncertainties, these should be regarded as working estimates rather than predictions, and response arrangements must be flexible enough to deal with a range of possibilities and capable of adjustment as implemented. Provided that the origin of a pandemic is outside the UK, emerging surveillance data might also allow the use of real-time modelling to confirm and/or refine these assumptions and presumptions.

To ensure a common approach drawn from the best available evidence, ambulance services are strongly advised to build their plans on the UK's influenza pandemic planning assumptions and presumptions, which can be found in the *National framework* (section 3) available at www.dh.gov.uk/pandemicflu

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Pandemic Influenza phases and triggers

The World Health Organization (WHO) has defined phases in the evolution of a pandemic that allow for a step-wise escalation in planning and response which is proportionate to the risk from first emergence of a new influenza virus. WHO will inform its member states of any change in phase, and this classification is used internationally. If a pandemic were declared, action would depend on whether cases had been identified in the UK, and the extent of spread. For UK purposes, four additional alert levels have therefore been included within WHO Phase 6; these are consistent with those used for other communicable disease emergencies.

Further information on WHO international phases and UK alert levels can be found in the *National framework* (section 5) available at www.dh.gov.uk/pandemicflu

A key component of ambulance service plans should be the development of healthcare triggers aligned with WHO international phases and UK alert levels.

To facilitate consistency of approach, these triggers should be developed in partnership with the local health community and agreed with local PCTs.

These triggers will, for example, assist ambulance trusts in deciding when to:

- initiate 'assess and leave' procedures
- support the rapid discharge of patients from acute trusts.

Ethical considerations

At the request of the Department of Health, an independent committee with cross-UK representation has developed an ethical framework to inform the development and implementation of health and social care response policy. The systematic use of the principles it contains can act as a checklist to ensure that all the ethical aspects have been considered at all levels.

Responding to pandemic influenza: The ethical framework for policy and planning is available at www.dh.gov.uk/pandemicflu

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Background

Table 1: WHO international phases and UK alert levels

Phase	WHO international phases	Overarching public health goals
Inter-pandemic period		
1	No new influenza virus subtypes detected in humans	Strengthen influenza pandemic preparedness at global, regional, national and sub-national levels
2	Animal influenza virus subtype poses substantial risk	Minimise the risk of transmission to humans; detect and report such transmission rapidly if it occurs
Pandemic alert period		
3	Human infection(s) with a new subtype, but no (or rare) person-to-person spread to a close contact	Ensure rapid characterisation of the new virus subtype and early detection, notification and response to additional cases
4	Small cluster(s) with limited person-to-person transmission but spread is highly localised, suggesting that the virus is not well adapted to humans	Contain new virus or delay its spread to gain time to implement preparedness measures, including vaccine development
5	Large cluster(s) but person-to-person spread still localised, suggesting that the virus is becoming increasingly better adapted to humans	Maximise efforts to contain or delay spread, to possibly avert a pandemic and to gain time to implement response measures
Pandemic period		
6	Increased and sustained transmission in general population UK alert levels 1 Virus/cases only outside the UK 2 Virus isolated in the UK 3 Outbreak(s) in the UK 4 Widespread activity across the UK	Minimise the impact of the pandemic

The role of ambulance services during an influenza pandemic

Responding to this significant challenge will require each section of the health community to prepare and plan for this eventuality, but this planning must be integrated across and within all those organisations that deliver health and social care services to the population. Only through this whole-systems approach will robust and effective healthcare be maintained under extremely demanding conditions.

Adding value to the response

Thirteen NHS trusts provide ambulance services across England. They will need to maintain local planning and readiness for pandemic influenza based on a common response strategy, integrated with local health plans. This strategy will provide the framework for:

- prioritising effort
- ensuring resilience arrangements locally, regionally and nationally, including strategic command, control and coordination arrangements.

The demands likely to be placed on ambulance trusts will bring these organisations to such a critical level that normal and routine activity will not be able to continue in the same form. This will be from both a patient demand perspective and a business continuity angle, principally concerning the provision of resources.

In their planning with PCTs and local multi-agency partners, ambulance services should address the following key questions:

- During an influenza pandemic, what services can safely be curtailed or downgraded?
- What resources are released as a result of this action?
- What is the impact of releasing these resources?
- How can these resources be put to best use, primarily in the local health response, but also in the multi-agency response?
- How can ambulance personnel be appropriately supported (including training and clinical supervision) to work differently in order to facilitate the principle of 'assess, treat and leave at home' for the majority of cases, triaging only the most unwell and vulnerable patients for transportation to hospital?
- What is the trust's own capability to continue its critical functions during an influenza pandemic?

In answering these questions, local planners should bear in mind that other illnesses and injuries will continue to occur, and that ambulance response capability for other emergencies needs to be maintained as far as possible.

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The role of ambulance services during an Influenza pandemic

Whole-systems approach to healthcare – Interfacing with the ambulance service response

Ambulance services, in partnership with PCTs and others providing access to NHS services, must develop a coordinated and consistent approach towards responding to patients. Linked to the coordination of methods of handling calls seeking help is the need for appropriate assessment that takes account of the patient's reported needs and the availability of resources according to the availability of care.

Overarching principles

- Ambulance trusts will play a vital role in acting as one of the main gateways to healthcare. For this to be effective, ambulance services must work in partnership with local PCTs, GPs, out-of-hours services, NHS Direct, emergency departments, minor injuries units, walk-in centres and others that provide access to NHS services, including the devolved administrations where appropriate. Pandemic-specific pre-hospital patient assessment and treatment protocols will need to recognise that hospital capacity will be extremely limited, emphasising treatment at home and ensuring that only patients with serious or life-threatening conditions are actually admitted into the acute sector. This work has been initiated nationally. Local response plans should also consider the extent to which the field assessment and treatment skills of ambulance staff could be utilised to support the wider delivery of home care.
- However, the process should not be viewed as starting with the ambulance professional arriving at the patient's location, but with the receipt of the call. Key, pre-prepared questions will need to be asked to ensure that the limited resources available are targeted to those most in need. A challenge in achieving this will be to ensure that the call prioritisation software used by ambulance trusts reflects these revised algorithms. This work has been initiated nationally, but will need to be completed as part of national influenza planning and preparedness.
- Effective communication strategies informing patients why their expectations may not be met are being developed nationally by the Department of Health's Pandemic Influenza Preparedness Team. In these scenarios, staff in ambulance service control centres will play a vital role in providing consistent and accurate advice and information. These messages must be consistent with advice provided by other health professionals and NHS Direct. Despite communication and education efforts, many patients and their relatives and carers may demand transport and it is acknowledged that this may increase call time significantly.
- Ambulance services have other experiences and resources that are vital when responding to pandemic influenza. Ambulance services, through their knowledge and understanding of command and control systems, are well placed, for

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example, to assist PCTs in the provision of a local influenza coordination arrangement, if appropriate and agreed locally.

- Many vulnerable patients of all ages and those with long-term conditions who are being cared for in their home setting are likely to be well known to some ambulance and other local services. The scheduling systems used for non-emergency patient transport services may be one component that can provide assistance in the planning and scheduling of healthcare to vulnerable patients in the home setting.
- Ambulance trusts should explore the potential role of primary care and emergency care practitioners during an influenza pandemic in conjunction with local healthcare providers and Local Resilience Forums (LRFs).
- The aim should be to transport to hospital only those patients who are most critically ill, in parallel with maintaining services to other patients, for example those receiving life-sustaining outpatient treatment or those injured as a result of accidents, and those receiving maternity care. For those suffering the complications of influenza, hospital capacity should be utilised for the seriously ill most likely to benefit.
- Ambulance trusts will play a vital role in the safe transport of patients away from acute settings, especially those sites implementing a policy of increased discharge rates as a result of the pandemic.

Department of Health guidance documents on pandemic influenza arrangements in the acute and community settings are available at www.dh.gov.uk/pandemicflu

Children

For ambulance services during the influenza pandemic, the principles for managing children should be along the same pathways as for adults, whilst taking into account their different physiology and needs. The severity of a child's illness may be more difficult to assess than that of an adult. They should therefore be seen by someone with the appropriate training and experience to make that assessment in a timely manner. Ambulance trusts are advised to build this contingency into their pandemic influenza plans.

Strategic command, control and coordination arrangements

Ambulance trusts work regularly with the police and fire and rescue services. This experience places the ambulance service as a useful link between the wider healthcare system and the resilience community, including supporting PCTs at LRFs and, in the response phase, Strategic Coordination Groups (SCGs).

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The role of ambulance services during an Influenza pandemic

As the clinical attack rate increases, consideration must be given to reducing or ceasing certain service provision in order to pool and target resources effectively. During the pandemic period (WHO Phase 6, UK alert levels 2–4), this may require daily assessment of resource availability. When considering the whole-systems approach, any reduction or cessation of service will need to be agreed with PCTs and strategic health authorities (SHAs), as there will be a knock-on effect elsewhere in the healthcare system.

The NHS command, control and coordination arrangements have been reviewed and revised to take account of the changes made to the organisation of the NHS and also to the needs of the service during a pandemic. Details are available from the *National framework* (section 4) available at www.dh.gov.uk/pandemicflu

Recovery

Ambulance trusts will need to consider, as part of contingency planning, a recovery strategy for the post-pandemic phase. Although the objective is to return to pre-pandemic levels of functioning as soon as possible, the pace of recovery will depend on the residual impact of the pandemic, ongoing demands, backlogs, staff and organisational fatigue and continuing supply difficulties in most organisations. Therefore, a gradual return to normality should be anticipated and expectations shaped accordingly. Plans at all levels should recognise the potential need to prioritise the restoration of services and to phase the return to normal in a managed and sustainable way.

Ambulance services are likely to experience persistent secondary effects for some time, with increased demand for continuing care from:

- patients whose existing illnesses have been exacerbated by influenza
- those who may continue to suffer potential medium- or long-term health complications
- a backlog of work resulting from the postponement of treatment for less urgent conditions.

The re-introduction of performance targets and normal care standards also needs to recognise loss of staff and their experience, and that other staff will have been working under acute pressure for prolonged periods and are likely to require rest and continuing support. Human resource issues will need to be considered carefully.

Work is in progress at a national level to produce specific advice on human resource issues – *Pandemic influenza: Human Resources guidance for the NHS* and it has been published for comment.

Facilities and essential supplies may also be depleted, resupply difficulties might persist and critical physical assets are likely to be in need of backlog maintenance, refurbishment or replacement. Impact assessments will therefore be required.

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Audit trails for both clinical and corporate governance purposes will need to be reviewed in preparation for any wider inquiry into the response, or for increased requests for information on the treatment provided to individuals. Any backlog of routine work that was put on hold, such as training and similar activity, may need to be prioritised to ensure that the service can continue to move forward.

Ambulance services should also consider developing arrangements for regrouping services between waves of the pandemic.

Clinical issues

Control of Infection

Work is in progress at a national level to produce specific ambulance service infection control guidance particularly relating to pandemic influenza and it will be published as soon as it is available.

Parts of the pandemic influenza guidance document *Infection control in hospitals and primary care settings* are also applicable to the ambulance service and this is available at www.dh.gov.uk/pandemicflu

Generally, limiting the transmission of pandemic influenza requires the application of tried, tested and proportionate basic infection control measures such as:

- staff education
- local risk assessments to inform decisions on control and protective measures, as required by the Control of Substances Hazardous to Health Regulations 2002
- documenting proportionate procedures, operational protocols and checklists
- the consistent application of basic hygiene and infection control measures
- timely recognition of symptomatic patients
- ensuring that staff are well informed about and adhere to procedures for the prevention of influenza transmission
- providing personal protective equipment (PPE) if occupational risk assessments have indicated that to be necessary and ensuring that staff are trained in its correct wear, limitations and use
- implementing enhanced cleaning routines to minimise the risk from contact with hard surfaces.

Further guidance on infection control measures is available from the Department of Health website at www.dh.gov.uk/pandemicflu or the Health Protection Agency website at www.hpa.org.uk/Infections/topics_az/Influenza/pandemic/fluplan.htm.

The use of face masks and respirators

Various types of surgical face masks and respirators are available, offering differing levels of protection and meeting agreed European and/or international normative standards. WHO recommends the use of surgical masks and particulate respirators at 95% efficiency by healthcare workers during a pandemic, and that symptomatic patients could themselves wear surgical masks to protect others, if circumstances make it absolutely necessary for them to leave home and logistical arrangements allow. However, standard Health and Safety Executive (HSE) guidance calls for higher specification FFP3 respirators for healthcare workers whenever respiratory protection

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is indicated in the UK, although it recognises that this may not be sustainable in the special circumstances of an influenza pandemic. Based on available evidence and current UK pandemic influenza infection control guidance:

- fluid-repellent surgical masks should be worn by healthcare workers who may be in close (within one metre) and/or frequent contact with symptomatic patients
- FFP3 standard disposable respirators should be worn when carrying out clinical procedures likely to generate aerosols of respiratory secretions from infected patients (eg dental drilling, intubation, aspiration), although such procedures should be avoided as far as possible. It should particularly be noted that fit testing of respirators and specific training on their use are essential.

Assessment

The assessment of patients can be divided into two broad elements: telephone assessment and face-to-face assessment. Work is being undertaken at a national level to develop appropriate changes to the prioritisation software used by NHS services. The intention is to help support the delivery of a consistent service across the NHS.

Telephone assessment

Existing telephone assessment systems used in ambulance services in the UK recognise that not all patients accessing 999 require an emergency ambulance response. A significant proportion of 999 calls are dealt with using alternate end dispositions (Category C), with either advice or an alternative arrangement for care being provided.

Face-to-face assessment

Although the majority of cases may be adequately dealt with through telephone assessment, there will remain a need for protocols to enable staff working in primary care, including ambulance staff, to assess and prioritise patients in order to decide who can reasonably be left at home. Such protocols would recognise the pressures that the local health service was experiencing and would be applicable to patients with complications of influenza as well as to those with unrelated illnesses or injury.

Access to accident and emergency departments and admission to critical care units

The demand for hospital admission can be expected to increase up to 440 new cases per 100,000 population per week at the peak of a pandemic, given a 50% clinical attack rate, and it is likely that demand for hospital admission will exceed available capacity.

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In such circumstances, referral and assessment decisions will have to differ from normal expectations. To do this effectively there must be clear, locally agreed methods in place, taking account of any national advice, to support staff charged with the responsibility for such decisions. The extent to which support may be required will vary with the clinical attack rate and the resulting clinical pressures.

The priority is to reduce illness and save most lives in a way that is fair. During the course of an influenza pandemic and the follow-on period, it is essential that ambulance trusts formulate and agree with other responding organisations (primarily primary and acute sector NHS trusts) explicit plans to maximise efficient use of these limited resources and that, during the pandemic, daily dialogue is maintained with these same organisations.

Further information on pandemic influenza guidance for the acute and primary care sectors is available at www.dh.gov.uk/pandemicflu

Treatment

During a pandemic, any patient who is ill with influenza-like symptoms will be advised to stay at home and contact the National Flu Line service by telephone for initial assessment and access to antiviral medicines, if that is indicated.

Detailed guidance on the provision of healthcare in a community setting in England is available at www.dh.gov.uk/pandemicflu

Ambulance trusts will need to give advance consideration to the care and management of anxious or distressed friends and relatives.

Mass fatalities

Local authorities are responsible for producing local multi-agency plans for managing excess deaths in conjunction with other partners, agencies and groups. Ambulance trusts must ensure that they are engaged in this planning process.

Business continuity

The guidance provided within this section aims to focus the attention of planners upon issues that may need to be specifically addressed in preparation for managing an influenza pandemic. Ambulance trusts are reminded that these pandemic-related areas should be included within, and as an extension of, trusts' business continuity management arrangements as required by *NHS Emergency Planning Guidance 2005* (section 1.6, page 8) and the Civil Contingencies Act 2004.

NHS Emergency Planning Guidance 2005 is available at www.dh.gov.uk/emergencyplanning

Further information on generic business continuity planning in relation to the Civil Contingencies Act 2004 is available at www.ukresilience.info/preparedness/businesscontinuity/index.shtm

The Cabinet Office has also produced specific contingency planning material in relation to pandemic influenza and this is available at www.ukresilience.info/publications/060710_revised_pandemic.pdf

In addition, ambulance trusts may wish to assess themselves against the new British Standard for business continuity management (BS 25999). Details are available at www.thebci.org/pas56.htm

Ambulance trusts are encouraged to review their business continuity plans to deal with the effect of disruption to essential utilities. The Estates and Facilities Division of the Department of Health has produced guidance to assist planners in this regard (HTM00) and this is available from the NHS Knowledge and Information Portal at www.knowledge.nhsstates.gov.uk

The following sections are a summary of some key considerations.

Workforce

The Department of Health is working with NHS Employers on the delivery of specific guidance on pandemic influenza-related workforce and human resource issues – *Pandemic influenza: Human Resources guidance for the NHS*, including staff indemnity, and has been published for comment.

Ambulance trusts should develop contingency plans for maintaining and expanding the workforce available to support additional ambulance service capacity, working jointly with trade unions and staff organisations. Ambulance trusts should place strong emphasis on the importance of maintaining staff safety, confidence and morale. Experience from previous events suggests that these are crucial issues in preserving workforce commitment and availability, and that staff absence is likely to increase if staff have concerns about their safety or the safety of their families.

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These preparations should include:

- identifying the skill base of existing staff and the areas in which they might reasonably be asked to work in the event of a pandemic. These staff may be:
 - working in existing ambulance trusts
 - working in other related areas, eg in hospitals
 - recently left, eg retired, reallocated or seconded
 - working off site
- identifying staff who have responsibilities as carers (for children, relatives, etc) that may impact on availability and affect rota planning, and making an assessment of the impact of the closure of schools, nurseries, day hospitals, etc on contingency arrangements for staffing
- considering the circumstances under which staff may be asked to undertake responsibilities that exceed their normal capacity and skill levels, and identifying what additional resources may be required, eg training, clinical supervision, debriefing, psychological support for staff and their families
- establishing mutual aid arrangements with neighbouring NHS and other organisations, eg by making arrangements for staff unable to travel to work who may be more easily able to attend facilities nearer to their homes and taking into consideration the distances travelled and methods of travel used by staff
- reassessing and restructuring staff rotas and reviewing minimum staffing levels
- making arrangements for residential accommodation for those staff unable to travel home
- establishing procedures, protocols and residential facilities for the accommodation of staff whilst working and for those who might be reluctant to attend work unless facilities are available to prevent the need to return home (because of concerns about disease transmission to their family)
- developing strategies for return to normality as the pandemic subsides. These should include the progressive, planned release and support of staff who may have been working under stress, and possibly continuously for a prolonged period.

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Training and support

Additional training and support may be required for existing ambulance personnel to enable them to respond appropriately to the demands of the pandemic. In addition to pandemic-specific programmes, this may include education on generic issues to enable the maintenance of services.

Standard infection control protocols and procedures should be reviewed and reinforced, and training should be provided where gaps are identified. During WHO Phase 5, ambulance services are advised to provide infection control refresher courses to their staff.

The HSE has produced pandemic-specific infection control guidance for the occupational setting and this is available at www.hse.gov.uk/biosafety/diseases/Influenza.htm

Support and training programmes must be developed for those members of staff who may be reallocated to other roles in support of pandemic influenza operations.

Training programmes must contain infection control advice for those ancillary workers (eg cleaners, vehicle workshop staff, technical and IT staff) who interact with emergency ambulance staff and vehicles, and thus are at risk.

Ideally, staff should be seconded to such courses on a rolling, regular-update basis in order to produce and maintain a high level of preparedness. However, it is also recognised that it may be essential to provide 'off-the-shelf' training at short notice.

Maintenance of the fleet and other services

The resilience of fleet support arrangements is essential during a pandemic. Ambulance trusts should assure themselves that both in-house and contracted services are resilient and, if required, additional arrangements should be put in place with alternative providers in the preparatory phase to strengthen these provisions. The following areas should be included:

- main dealer support
- in-house maintenance
- auto-electrical support
- tyre supply and fitting.

Specifically, agreements should be reached with vehicle manufacturers regarding work undertaken during an influenza pandemic which may need to be undertaken by non-approved contractors to prevent the infringement of vehicle warranties, which may have long-term financial consequences.

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Business continuity

The role of the voluntary and Independent sector

The demand on voluntary and independent resources should not be underestimated. Unlike conventional, short-lived periods of increased demand where such resources may be deployed, support during a pandemic is likely to be required for approximately 12 to 16 weeks at a time. Trusts, along with the local health community, should therefore engage with voluntary providers, voluntary aid societies and the independent sector early in order to ascertain their capacity and resilience for such prolonged engagement. The engagement of other voluntary and independent providers not routinely used by ambulance trusts should also be considered. A collective approach with the health community, LRFs and Regional Resilience Forums is encouraged, to ensure the most effective use of these important resources and to prevent 'double counting'.

Financial controls

The response to a pandemic will place particular challenges upon trusts' financial procedures due to the demand for urgent resupply and possible stockpiling of resources. Whilst it is important to deal with the unusual demand by using normal systems, it is essential that trusts ensure that finance, and particularly procurement systems (and the staffing to support these), are robust. Engagement with trust bankers should identify fall-back arrangements to ensure continued access to funds in order to continue paying staff and essential suppliers throughout the pandemic period.

Mutual aid

Ambulance services should review their existing arrangements for mutual aid. However, it is unlikely that support will be available from neighbouring services, which in all probability will be experiencing the same levels of high demand and staff absence.

Data collection and transmission – focused data collection systems

Discussions are being conducted nationally to agree what information will be required from situation reports, and the method and likely frequency of collection. Once this information is available, ambulance trusts should ensure that appropriate support systems are in place to facilitate the effective linkage to these arrangements both locally and nationally. Time will need to be factored in to plans for the required data collection and reporting.

Equipment and supplies

Ambulance trusts should review their inventory of resources in order to facilitate access in abnormal circumstances and to assist in determining priorities during the pandemic.

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Ambulance trusts should give consideration to what additional equipment and supplies – including masks, gowns and other PPE, respiratory circuit filters and other essential respiratory support apparatus, and core pharmaceuticals/oxygen/disposables – might be needed to sustain their response during an influenza pandemic.

The potential for disruption to the supply chain due to staff absence or fuel shortages should be considered. Trusts may wish to increase stock levels of equipment and supplies that are normally maintained on a 'just-in-time' resupply basis, such as medical and PPE consumables, medical gases and vehicle fuel and parts.

Consideration should be given to plans for the storage of equipment to support an influenza pandemic response, how such equipment will be accessed, and to the maintenance of critical supply and delivery chains. Ambulance trusts are encouraged to engage in discussions with other healthcare partners on this issue to ensure consistency of approach in the local health economy.

Advance planning will enable ambulance services to make the most efficient use of limited resources in an escalation setting. This could include collaborative agreements with neighbouring healthcare services on the use of combined storage and stockpiling of agreed resources. Similar agreements could be undertaken relating to disposable equipment and PPE. The use of memoranda of understanding between trusts should be considered to ensure that there is clarity about what equipment, supplies and other resources are being held and the basis for access and use.

It is essential that critical logistic and supply chain arrangements are robust. Trusts are encouraged to be fully conversant with their suppliers' (influenza pandemic) business continuity arrangements and, if required, consider alternative arrangements for supply chain requirements.

Leadership

Chief executive and the board

The chief executive and the board of each ambulance trust should take overall control of the preparations being made to respond to an influenza pandemic. Whilst it may be appropriate to delegate the task of preparation planning, the chief executive and the board should retain an active interest in progress, and should be represented at director level at NHS influenza pandemic preparedness planning group meetings.

The chief executive should:

- set up an influenza pandemic planning group
- nominate an influenza pandemic coordinator
- routinely monitor the progress of pandemic arrangements
- require routine exception reports on outstanding issues
- ensure that appropriate arrangements are in place to test and exercise plans
- ensure that plans are fully integrated with the local health community and multi-agency partners and agreed with local PCTs
- ensure that appropriate arrangements are in place to support and train staff
- ensure that arrangements are in place to keep staff fully informed about planning and preparing for a pandemic.

The influenza pandemic coordinator should:

- develop, test and review plans
- seek out examples of best practice in pandemic influenza planning
- keep staff informed
- liaise with PCTs, acute trusts, SHAs and the Health Protection Agency
- communicate with the private and voluntary sector
- liaise with primary care services so that GPs are aware of likely restrictions on ambulance response, and hence may encourage care of patients in the home environment
- raise awareness of problems and direct people towards relevant information
- keep the Department of Health and other ambulance services informed about the local response so that regional and national plans can be adjusted accordingly (eg pass on evidence obtained during a disease epidemic which provides information on its likely peak, duration, infectivity and mortality rates).

Annex: Resources and information

Strategy and planning

The UK national framework – *Pandemic flu: A national framework for responding to an influenza pandemic* – is available at www.dh.gov.uk/pandemicflu

Other Department of Health guidance on planning and preparing for an influenza pandemic, including material specific to the acute, primary and social care sectors is also available at www.dh.gov.uk/pandemicflu

Further information on the Civil Contingencies Act and Regional and Local Resilience Forum arrangements is available at www.ukresilience.info/preparedness/ccact.aspx

Further information on the care of influenza patients in the acute, primary and community and social care settings is available at www.dh.gov.uk/pandemicflu

As part of its role in supporting the Department of Health in preparing and planning for a possible influenza pandemic, the Cabinet Office has issued advice to assist business continuity planning – *Guidance on contingency planning for a possible influenza pandemic*, *Pandemic influenza checklist for businesses* and *Introductory advice to staff on planning for pandemic influenza* – which are available at www.ukresilience.info/publications and www.preparingforemergencies.gov.uk

The World Health Organization (WHO) has produced a planning framework through its *WHO global influenza preparedness plan (2005)* and a planning checklist, which are available at www.who.int/csr/resources/publications/Influenza/GIP_2005_5Eweb.pdf and www.who.int/csr/resources/publications/Influenza/FluCheck6web.pdf

The *NHS Emergency Planning Guidance 2005* is available at www.dh.gov.uk/emergencyplanning

Clinical Information

More detailed information on influenza viruses, the illness they can cause and the impact of past pandemics is available at www.dh.gov.uk/pandemicflu

Further information on the human and animal health aspects of avian influenza is available from the Department for Environment, Food and Rural Affairs at www.defra.gov.uk, the Department of Health at www.dh.gov.uk/pandemicflu, the Health Protection Agency at www.hpa.org.uk, WHO at www.who.int/csr/en and the World Organisation for Animal Health at www.oie.int/eng/en_index.htm

Further information on clinical guidelines and infection control can be found at www.dh.gov.uk/pandemicflu

Guidance to employers is available via the Health and Safety Executive website at www.hse.gov.uk/biosafety/diseases/pandemic.pdf

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Business continuity

Guidance on the clinical management of patients with influenza-like symptoms during a pandemic is available from the following websites:

British Thoracic Society – www.brit-thoracic.org.uk/PandemicFlu.html

Department of Health – www.dh.gov.uk/pandemicflu

British Infection Society – www.britishtinfectionsociety.org

Health Protection Agency –
www.hpa.org.uk/Infections/topics_az/Influenza/pandemic/default.htm

Further guidance on infection control measures is available from the Department of Health at www.dh.gov.uk/pandemicflu and the Health Protection Agency at www.hpa.org.uk/Infections/topics_az/Influenza/pandemic/fluplan.htm

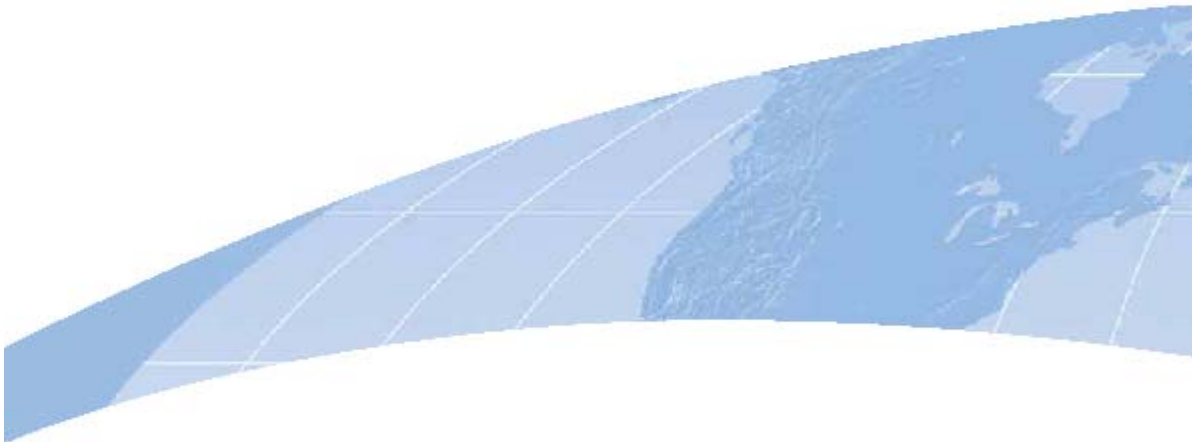
Business continuity

Further advice on business continuity aspects is available on the UK Resilience website at www.ukresilience.info/ccact/ep_chap_06.pdf

Further advice on the new British Standard for business continuity management (BS 25999) is available from the Business Continuity Institute's website at www.thebci.org

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November 2007

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Appendix J

Patient Treatment and Assessment Algorithms

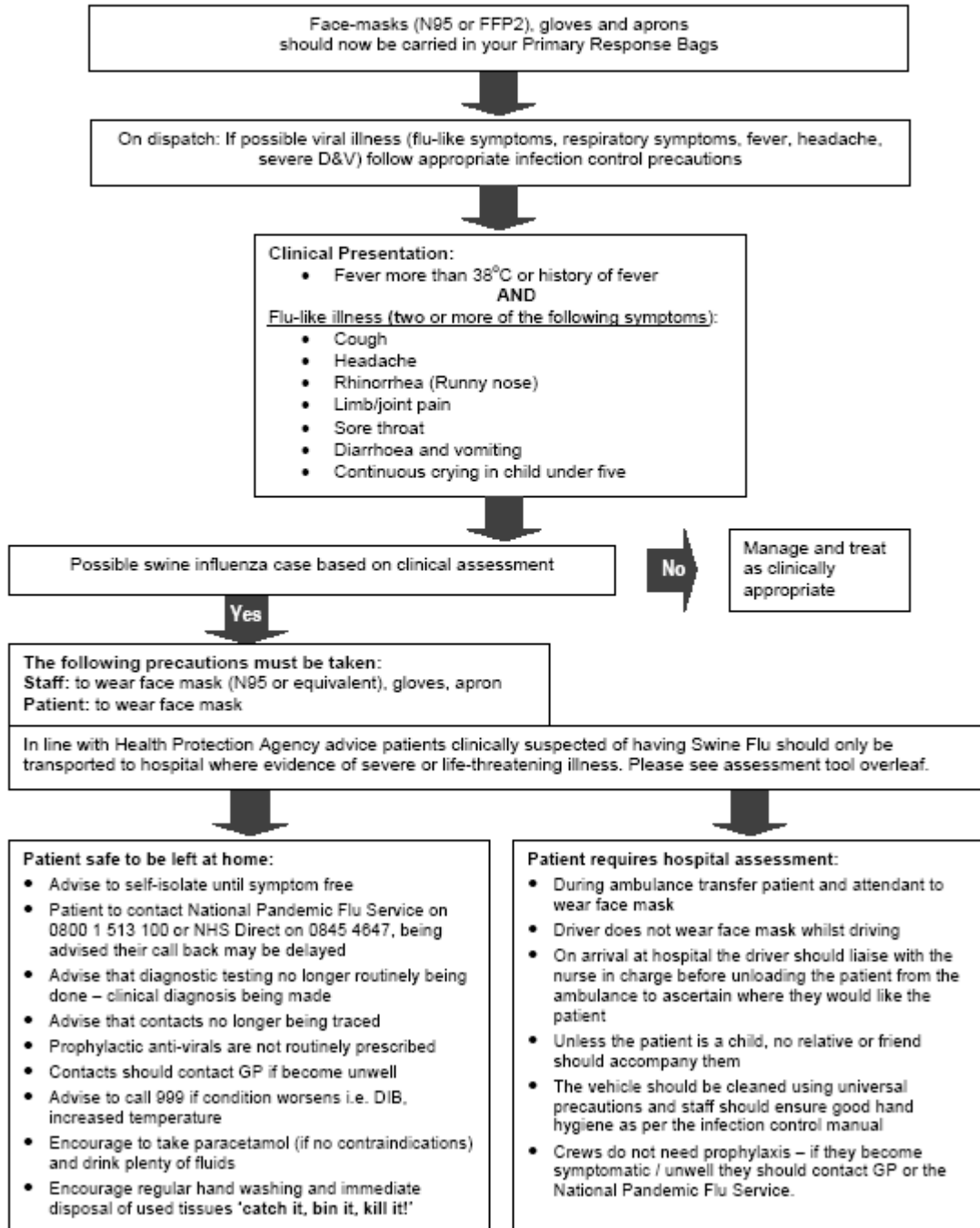
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London Ambulance Service **NHS**
NHS Trust

Flow chart for management of patients with flu-like illness



Further specific advice will be issued to EOC/UOC staff. Specific queries should be directed to the Clinical Support Desk via sector desks.

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Swine flu adult and children community assessment tool

- This assessment tool is designed to support and empower frontline staff to advise patients with flu-like symptoms on community assessment / care, but does not supersede a decision made by an experienced clinician of whether, when, and where to refer a patient.
- The assessment applies to patients aged over 12 months. All children under one year should be transferred to the local emergency department unless a GP appointment is available within one hour as they are at high risk of suffering severe illness.
- This assessment tool applies to all patients with no prior or existing medical condition including pregnancy. All patients with underlying medical conditions or who are pregnant should be advised to contact their GP.
- If patients are safe to be managed in the community they should be advised to call the National Pandemic Flu Service on 0800 1 513 100.

Adults should be assessed and referred to the nearest A&E if they present with any of the following:

- **Severe respiratory distress**: Severe breathlessness (unable to complete sentences in one breath), use of accessory muscles, supra-clavicular recession, tracheal tug or feeling of suffocation
- **Increased respiratory rate** measured over at least 30 seconds ≥ 25 breaths per minute
- **Oxygen saturations** $\leq 94\%$ (on pulse oximetry) breathing air or $\leq 88\%$ on home oxygen therapy. Absence of cyanosis is a poor discriminator for severe illness
- **Respiratory exhaustion** – new abnormal breathing pattern e.g. alternating fast and slow rate or long pauses between breaths
- **Abnormal pulse rate** – new abnormal heart rate e.g. < 50 bpm or > 100 bpm
- **Evidence of severe clinical dehydration or clinical shock** – systolic blood pressure < 90 mmHg and / or diastolic, 60 mmHg. Sternal capillary refill time > 2 seconds, reduced skin turgor
- **New confusion** – any altered level conscious level, striking agitation or seizures
- **Other clinical concern** – photophobia, non-blanching rash, or severe underlying medical condition eg COPD, heart disease, renal disease.

Children aged 1-16 years should be assessed and referred to the nearest A&E if they present with any of the following:

- **Severe respiratory distress**: Lower chest wall indrawing, sternal recession, grunting or noisy breathing when calm, unable to complete sentence in one breath
- **Increased respiratory rate** measured over at least 30 seconds ≥ 40 breaths per minute if aged over 1 year, ≥ 30 breaths per minute if over 5 years, ≥ 25 breaths per minute if over 12 years
- **Oxygen saturations** $\leq 95\%$ (on pulse oximetry) breathing air. Absence of cyanosis is a poor discriminator for severe illness
- **Respiratory exhaustion / Apnoeic episode** – new abnormal breathing pattern e.g. alternating fast and slow rate or apnoea lasting ≥ 20 seconds
- **Evidence of severe clinical dehydration or clinical shock** – Sternal capillary refill time > 2 seconds, reduced skin turgor, mottled / cold peripheries, sunken eyes/ fontanelle. Poor urine output
- **Any altered conscious level** – strikingly agitated or irritable, inconsolable crying or seizures or floppy
- **Other clinical concern** – photophobia, non-blanching rash, or severe underlying medical condition e.g. congenital heart disease, prematurity, chronic lung disease, severe asthma

**London Ambulance Service NHS Trust
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20 August 2009

Protocol 36 revised Emergency Operations Centre information

Due to the ever changing nature of the flu pandemic, a decision has been taken to revise the way protocol 36 is used.

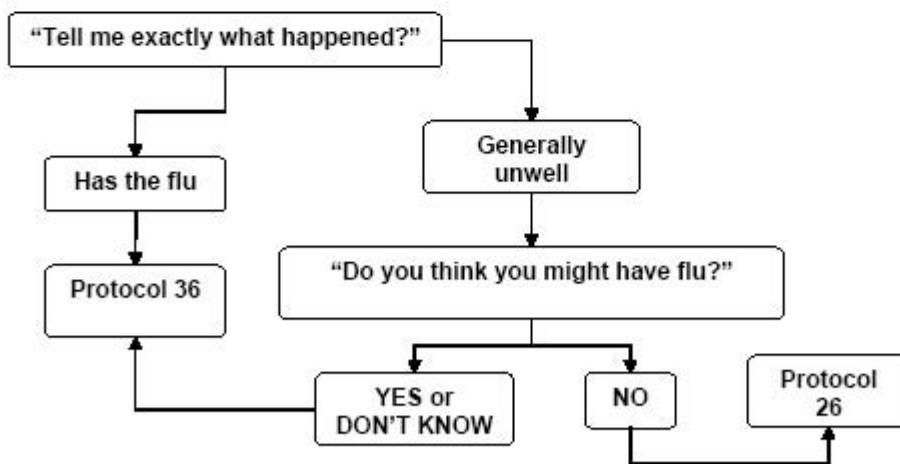
Protocol 36 is to be used **only** for patients who are between 5 and 65 years old (inclusive)

All calls where the patient presents with 'chest pains' will be triaged using **protocol 10**.

All calls where the patient has a 'headache' will continue to be triaged on protocol 36.

Calls where the patient has 'difficulty in breathing' will continue to be triaged on protocol 36, unless the patient has a 'known respiratory illness' (severe asthma, COPD, emphysema) and presents with 'breathing problems', in which case they should be triaged using **protocol 6**

If the caller suspects that the patient has 'swine flu' or is 'generally unwell' the following applies:

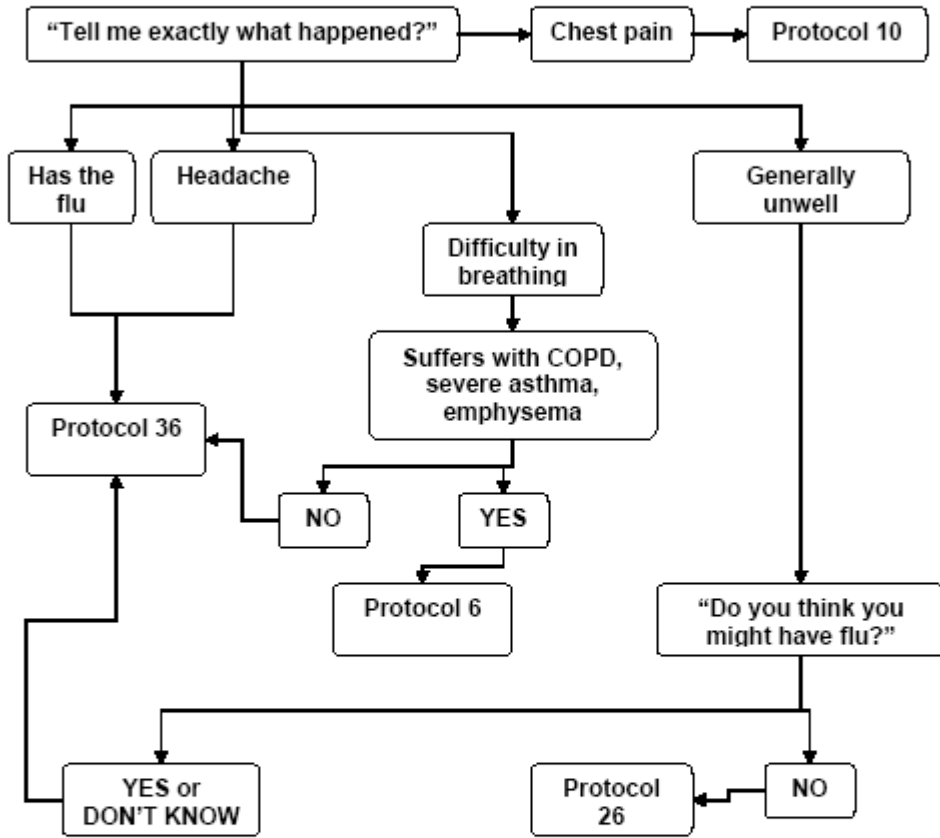


If at any time you suspect the patient has meningitis or is having a sickle cell crisis, ensure you select protocol 26.

See reverse

Control Services

Protocol 36 flowchart



Fenella Wrigley

Fenella Wrigley
Assistant Medical Director

Paul Webster

Paul Webster
Performance Improvement Manager

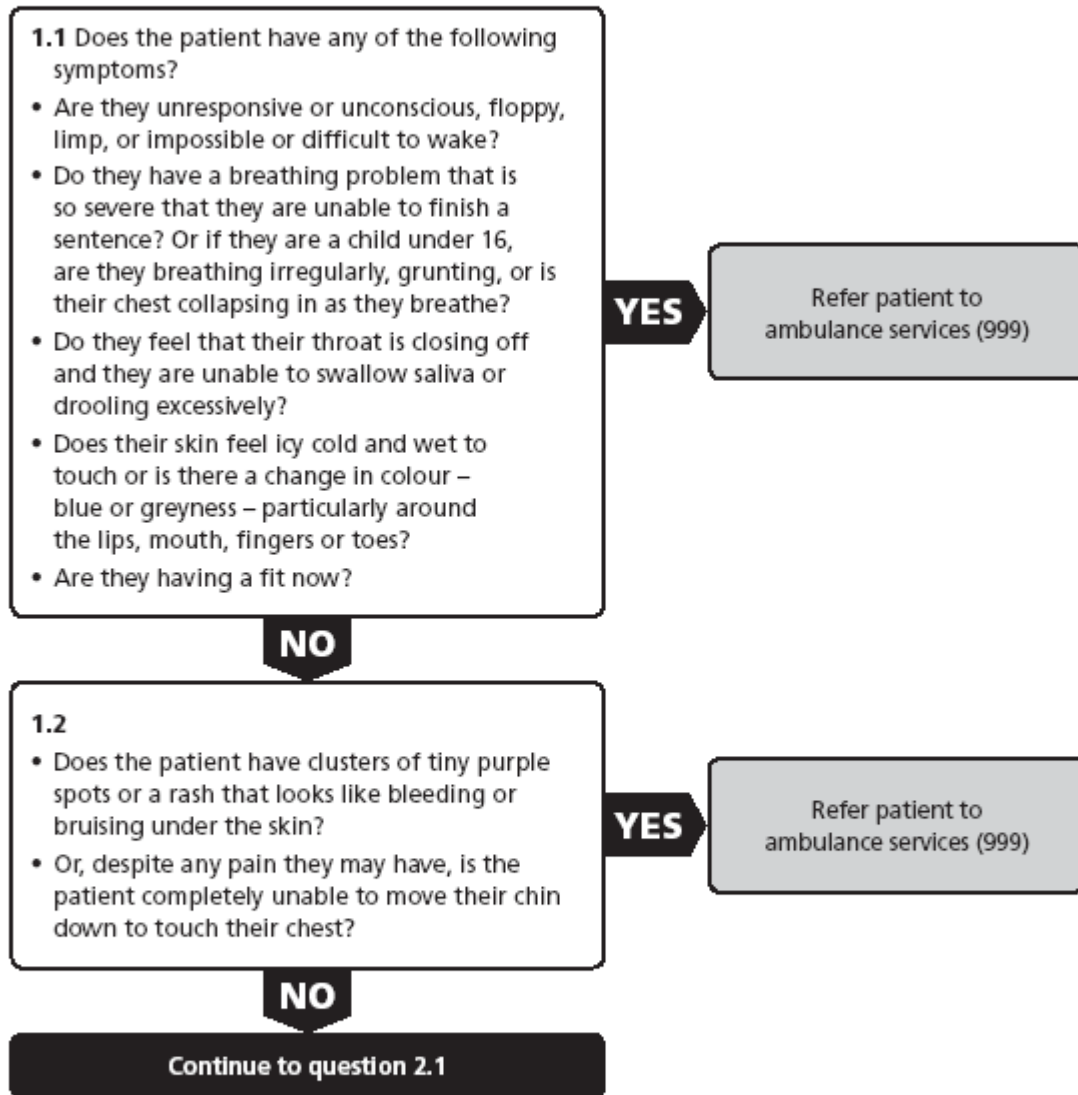
SWINE FLU ASSESSMENT – CLINICAL ALGORITHM



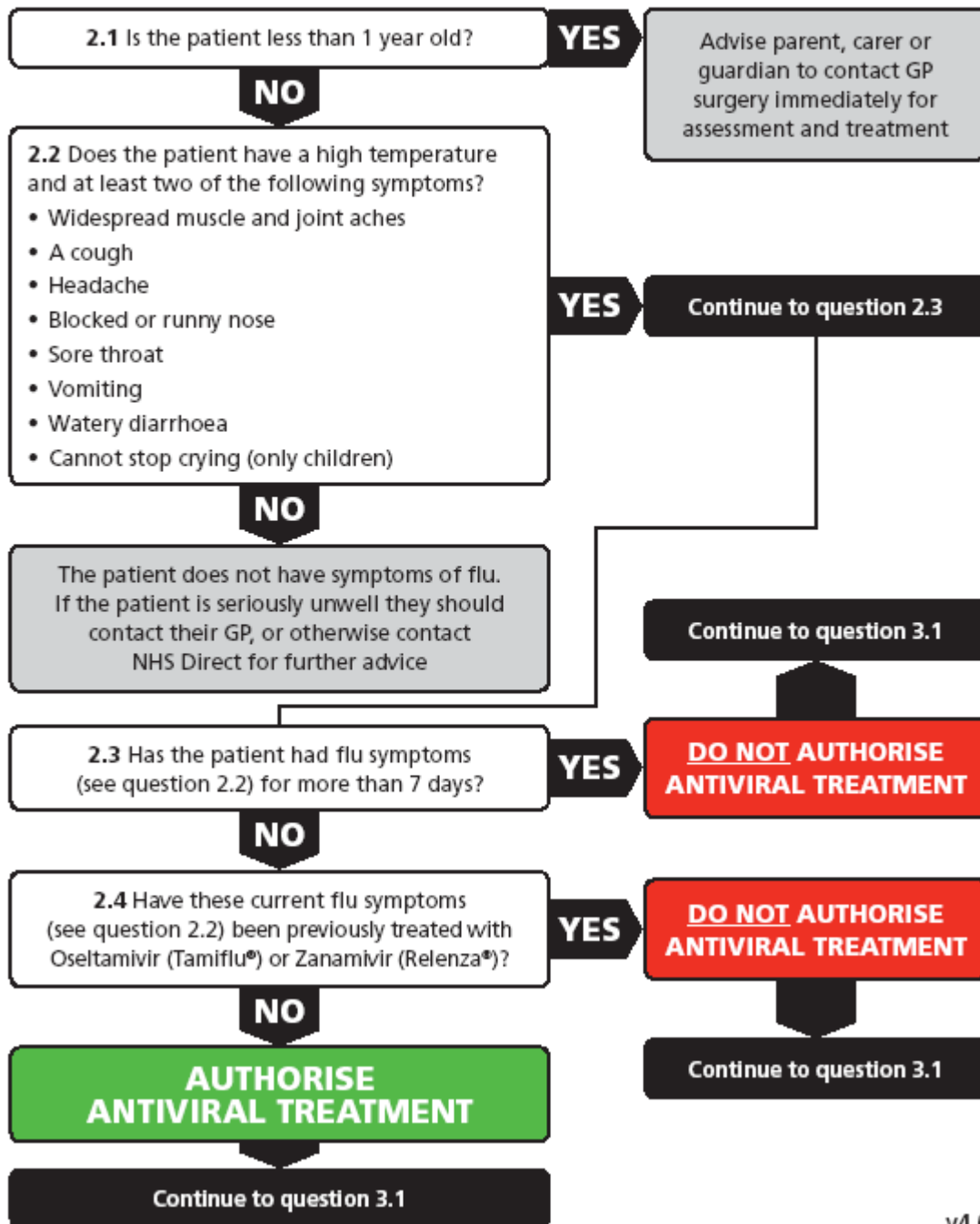
Guide for use

- This algorithm is intended to be used to assess patients over 1 year old. It is not for assessment of children under 1 year.
- The assessment includes a series of questions concerning the patient's current symptoms and their medical history.
- Unless the patient requires an emergency referral to 999, the algorithm should be completed to the final question for each patient assessment.
- The assessment involves three steps:
 - STEP 1** – Determine whether the patient requires ambulance services (999)
 - STEP 2** – Confirm that the patient has flu symptoms and would benefit from antiviral treatment
 - STEP 3** – Identify whether the patient requires additional healthcare services
- Step 1 will identify patients who need emergency care. These patients should be directed to ambulance services (999) immediately.
- Step 2 will determine whether a patient should be authorised to receive antiviral treatment. If antiviral treatment is required, information about the patient must be used to authorise the correct antiviral for the patient.
- Step 3 will determine whether the patient should seek further assessment or advice from another healthcare service, and provide appropriate advice for the patient.

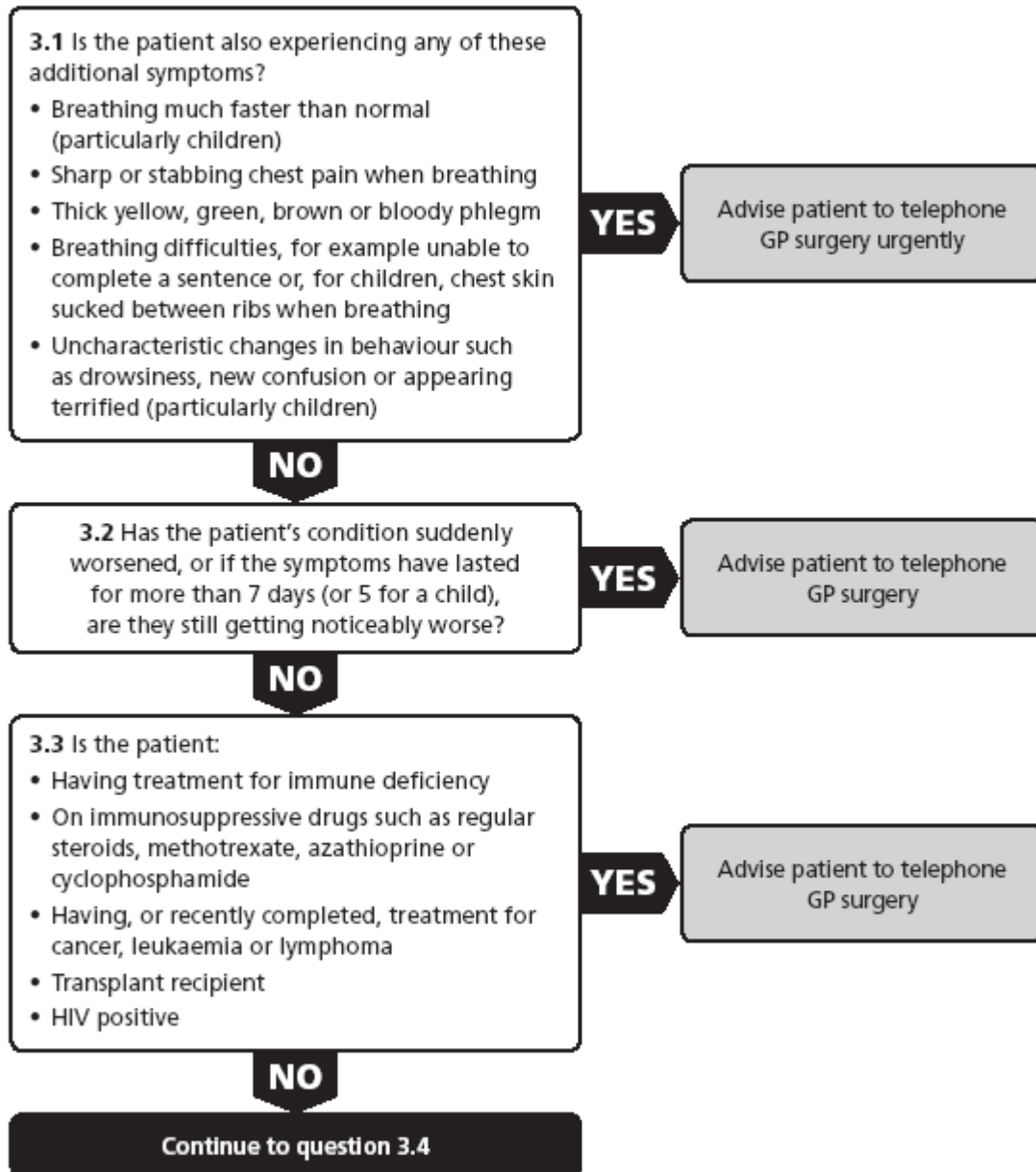
STEP 1 – Emergency Assessment

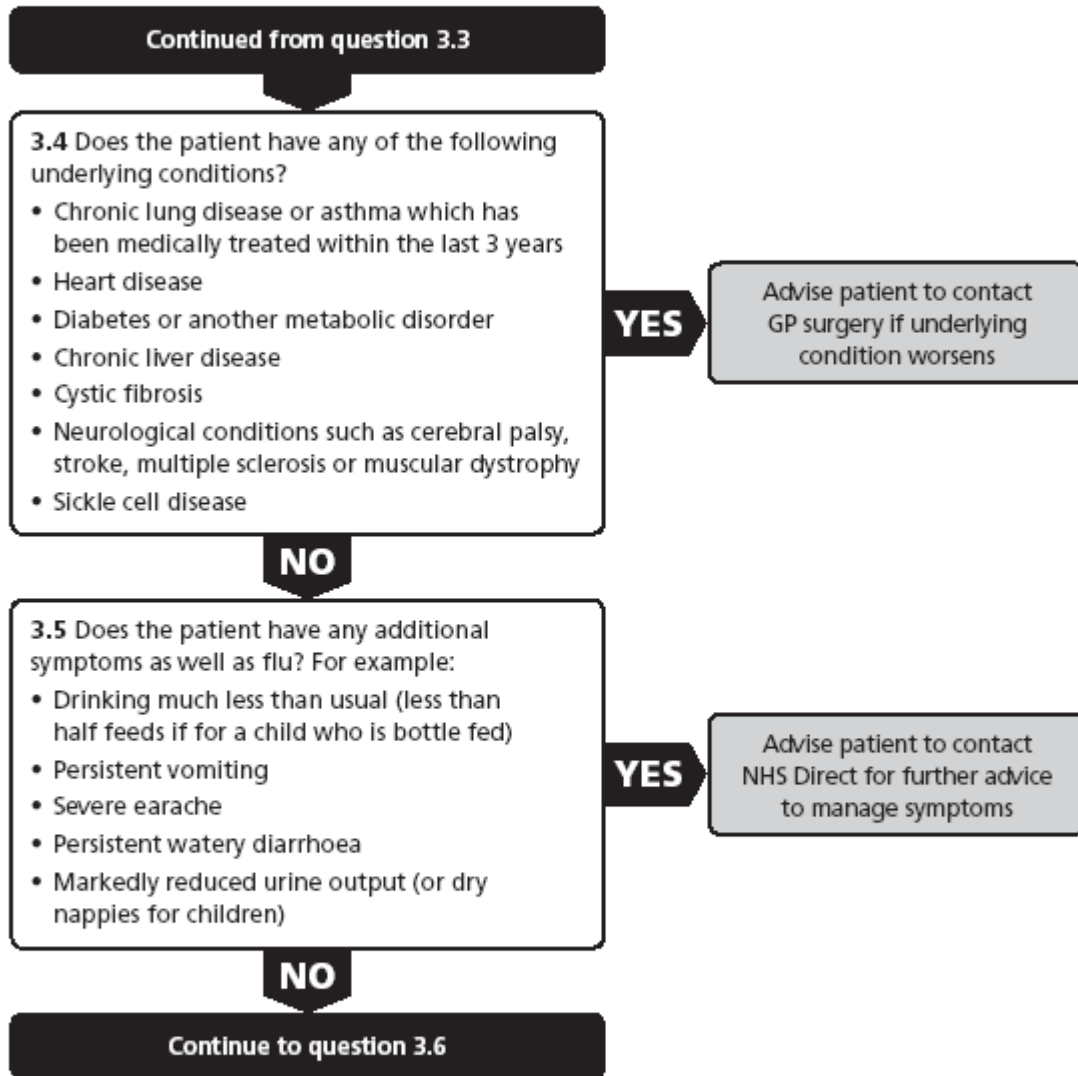


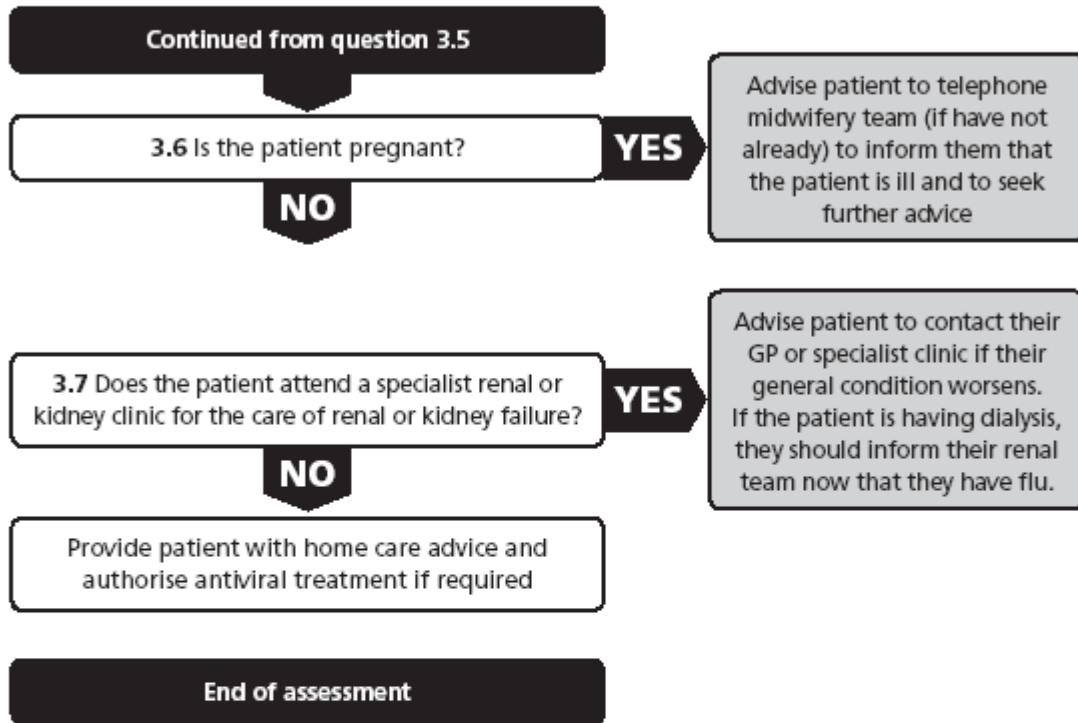
STEP 2 – Flu assessment and authorisation of antiviral treatment



STEP 3 – Identify whether further assessment or advice is required







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Appendix K

SHA Flu and Winter Checklist

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London Ambulance Service NHS Trust
Winter and Flu Planning Framework 2009/10

Winter and Flu Resilience plans checklist

Organisation name: London Ambulance Service

Board meeting date: 29 September 2009

Sl	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria ARSD - assessed and ready now AMBER - in progress complete by end Sept RED - in progress complete after end Sept	If RAG status is not predicted completion date	Page / para ref in Flu and Winter resilience plans
Health economy wide issues						
1	Leadership - organisations in the Health Economy demonstrate joined up multi-agency approach to planning. Flu Resilience plans for each organisation in the Health Economy have been shared and agreed. Agreements in place on any local cross border issues to ensure patient care is seamless.	Y	Y			62
2	Local leaders - every organisation has senior leadership arrangements in place to manage Flu and Winter resilience which is clearly documented. There is a reliable system in place for keeping the CEO, Board and Flu Lead Director apprised of progress, receiving exception reports and for escalating their involvement as required.	Y	Y			37
3	SITREP reporting - every organisation has in place robust procedures to comply with all SITREP reporting processes.	Y	Y			62
4	Resilience plans tested - assurance that both Winter and Flu resilience plans have been tested or exercised particularly known stress points in the plan.	Y	Y			38
5	Infection control - plans take into account both Swine Flu and also major increase in activity in 'surge' conditions.	Y	Y			44
6	Escalation processes - there is a clear well communicated multi-agency plan for health economy response to 'surge' demand that is owned and shared with all key health and social care partners in the health economy. The trigger levels to move to each escalation level are well defined and understood by all agencies.	Y	Y			13
Patients						
7	Antiviral Collection Points - facilities in place so that anyone with suspected swine flu gets issued with antivirals within 48 hours including those patients without a GP and vulnerable groups - include ICTs full roll out plan of ACPs.	N				
8	Vaccination programme for each PCT's patients is in place and is flexible enough to respond to vaccine supply issues and priority group issues.	Y	Y			40
Winter resilience plans						
9	Discharge processes - multi-agency co-ordination to minimise the number of delayed transfers of care.	N				
10	A&E performance - specific plans to cope with 2 known dips in A&E performance early December and early January.	Y	Y			11
11	Business continuity - evidence that organisation has a robust plan to respond to issues such as bad weather (snow).	Y	Y			28
Flu Pandemic second wave resilience						
12	Enhanced capacity in 'surge' demand- details of capacity that can be made available in each organisation for each key service including staffing and equipment resources. Details of the trigger levels to release this capacity into the organisation.	Y	Y			15
13	Capacity modelling - each health economy has taken account of worst case scenario set out by DH in July 2009 and has plans in place to respond to the peak weeks of the pandemic.	Y	Y			9
14	Essential services- plan identifies clinical and non-clinical essential services that must continue to be provided or that can be scaled back in a pandemic, as well as identifying critical and non-critical functions	Y	Y			28
15	Logistics - plans identify and regularly review key vital supplies, without which the trust could not function, and include local plans as to how these supplies can be maintained (e.g. utilities, food, linen, medical supplies)	Y	Y			51
16	Communication - plan for effective communication to staff, patients and the wider community before, during and after the pandemic.	Y	Y			58
17	Recovery from pandemic - plan includes detail on recovery from a pandemic.	Y	Y			75

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**London Ambulance Service NHS Trust
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Winter and Flu Resilience plans checklist

Organisation name: London Ambulance Service

Board meeting date: 29 September 2009

No	Action	Relevant to organisation (Y/N)	Included in resilience plan (Y/N)	Organisation overall assessment of readiness against criteria ARSD - assessed and ready now AMBER - in progress complete by end Sept RED - in progress complete after end Sept	If RAG status is not predicted completion date	Page / para ref in Flu and Winter resilience plans
Specific organisational capacity issues						
18	Acute hospital capacity – senior clinical decision making for initial assessment of emergency admissions / inpatient capacity / A&E - UOC interface / Maternity Services Capacity – clear policies exist which prioritise women who need hospital care and limit unnecessary admission.	N				
19	Critical care capacity – organisation has been through critical care checklist provided by DH (available early August) and have specific plans to increase capacity by 100% to respond to Flu and clear and agreed prioritisation plans.	N				
20	Primary care capacity - including normal GP capacity and out of hours services. Plans in place to ensure that those most likely to access healthcare services have care plans to reduce the likelihood that they will be admitted.	N				
21	Intermediate care capacity – implementing simplified access criteria, enhancing admission avoidance and palliative care services.	N				
22	Social care capacity – streamlining placement process, understanding total potential nursing and residential home capacity to work through with ability to raise capacity. Plans in place to ensure social care services resilience.	N				
23	Mental Health capacity- robust acute psychiatric liaison services to minimise A&E breaches and timely assessment of inpatients.	N				
24	Ambulance capacity - plans from each hospital to deliver the required 'hand over' waiting time targets.	N				
25	Diagnostic and therapy capacity – enhanced levels of services working 7 days per week in both primary and secondary care.	N				
Staffing						
26	Seasonal and Swine Flu vaccination plans for organisation's staff, that promises staff to be vaccinated according to service needs.	Y	Y			40
27	Medical staff plans - demonstrate that have recruited sufficient staff to cover BWTG roles in all critical services and that number of medical staff available take account of the busiest times of day. If the decision is taken nationally for a temporary derogation of WTD compliance to be instated, the terms and conditions of job offers to all medical staff are amended to reflect this.	N				
28	Maximise available staffing levels in all roles during an influenza pandemic, including arrangements for temporary postponement of all training, appropriate re-deployment of staff, re-employment of newly retired staff or staff who have left recently, flexible working arrangements (part-time to full-time, working at home, etc) and refresher course for staff who have a clinical background, but who no longer practice.	Y	Y			28
29	Response to likely absence levels due to sickness, caring responsibilities and the impact of the anticipated closure of schools, that are not reliant on temporary staffing solutions. Cover arrangements are in place for all key members of staff who may be taken ill, such as CEO, the Board, senior clinicians, and Flu Resilience team. Review of all policies that may affect staff attendance to ensure that they clarify how staff should report sickness during the pandemic.	Y	Y			28
30	Engagement with the Trade Unions to ensure their contribution and support for staff arrangements over the period of the pandemic.	Y	Y			58

Note:
PCTs may wish to complete separate checklist for Commissioning and Provider functions

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**London Ambulance Service NHS Trust
Winter and Flu Planning Framework 2009/10**

Appendix L

Ian Dalton Letter of 2nd July 2009

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**London Ambulance Service NHS Trust
Winter and Flu Planning Framework 2009/10**



Richmond House
70 Whitehall
London
SW1A 2NS
020 7210 4850
ian.dalton@dh.gsi.gov.uk

GATEWAY REFERENCE : 12125

TO: SHA, PCT, Acute trusts, Mental health, Ambulance, FTs CEa
CC: SHA, PCT, Acute trust, FT chairs, Monitor and CQC, LA CEa

2nd July 2009

Dear Colleague,

A (H1N1) Swine Influenza: Update and Resilience Actions for NHS Boards

On 11 June the World Health Organisation raised its alert level to 6, recognising that A(H1N1) swine flu has spread to pandemic levels. The virus is increasingly widespread within the UK and is expected to continue to spread rapidly. In the last week, we have seen a significant increase in the number of cases and an increasing number of hotspot areas emerging.

We knew that our containment strategy would buy some time in the early stages of this pandemic to better understand the virus and this has been successful. The scientists were always clear that it would not be possible to contain or prevent the spread indefinitely.

Ministers **across the UK** have today agreed that now is the time to move from a containment strategy to a treatment strategy which will focus the NHS' efforts on treating those who have the virus and its complications. The purpose of this letter is to make clear our expectations of you and your Boards concerning preparedness prior to any subsequent attack wave. **Enclosed with this letter is further detailed guidance making clear what this means for you and your organisations.**

I am in discussion with MONITOR about the importance of a system-wide response on this issue and they support the need for NHS Foundation Trusts to be a full part of this.

Due to the efforts of all NHS organisations in recent years, the NHS is well prepared to deal with a flu pandemic. Preparations for a flu pandemic include excellent stocks of antivirals and antibiotics as well as plans to vaccinate people. I want to emphasise that the response from the NHS to date has been very good although there has inevitably already been some evidence of localised pressure in areas with widespread community transmission. Looking forward however, there is no room for complacency. While there is

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Winter and Flu Planning Framework 2009/10**

some uncertainty about how the situation will develop, you must plan for every eventuality. The pandemic swine flu virus is a novel strain and its potential impact on the NHS' capacity and operations could be significant, even in the face of the pandemic plans you have all developed in recent years.

While the scientists cannot yet predict the future spread of the virus with any precision, past pandemics of 1957-58 and 1968-69 can help us to plan for what may lie ahead. They indicate that it is prudent to plan for a second – and potentially - more severe wave of the virus later in the year. All NHS organisations should therefore work on the assumption that their organisation needs to be at peak preparedness by September.

You and your Board need to ensure that your organisational focus and resources devoted to this work are sufficient in the context of the WHO declaration of a global pandemic and the prospect of a sustained second wave of up to five months duration. Preparing for every eventuality is a key governance issue for all NHS Boards (including NHS Foundation Trusts), and something that the public will be expecting of the NHS at this time.

It is in this context all NHS Boards should:

1. Appoint a full time director level lead dedicated to flu preparedness and resilience with immediate effect. This can be a single individual or shared between directors but must provide visible, full-time, senior leadership and ensure a well-resourced team on this issue through the months ahead.
2. Stress-test your pandemic preparedness plans to ensure that the provision of high quality care to flu and non-flu patients now and during a second, sustained wave of up to five months can be sustained.
3. Understand and test capacity constraints that may be caused through increased demand and workforce sickness absence. This includes but is not limited to those clinical areas that are likely to face most flu-related pressures. Recent '*Pandemic Flu: Managing Demand and Capacity in Health Care Organisations (surge)*' guidance and the NHS Employers/ Department of Health document '*Pandemic Influenza Human Resources Guidance for the NHS*' will help with this work.
4. Engage in discussion with Trade Unions about a staff vaccination programme and wider communications to and support for staff.
 - a. When we have a vaccine we will want to encourage as many staff as possible to participate in the programme to protect themselves, their families and their patients.
 - b. We want to ensure clarity for all about the support that we are putting in place for staff.
5. Build on existing relationships with local partner agencies to ensure that their role, channels of communication and ways of working during a second, sustained wave are clear.

In addition, all acute trust Boards, including Foundation Trusts will need to:

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Winter and Flu Planning Framework 2009/10**

6. Support the sentinel surveillance system on patients hospitalised with swine flu which will be used to provide advice on clinical management. Notify Joanne Enstone, the system coordinator, of details of a contact point within your Trust for arranging visits to collect data on such patients (Joanne.Enstone@nottingham.ac.uk).

In addition, PCT Boards will need to:

7. Ensure that antiviral collection points (ACPs) are effectively stood up, with *at least one* ACP in each PCT area to be operational by the beginning of next week, with more where the current level of swine flu in the community warrants it.
8. Ensure that local plans are in place for the Introduction of the National Pandemic Flu Service, including establishing a *network* of ACPs to meet the needs of local communities. Preparations are at an advanced stage and we expect that the service will be ready to be stood up, if needed, by the middle of July.
9. Continue to ensure that communications with and support to GPs (as patients' primary source of contact) are clear and help to maintain public confidence in our approach to managing the pandemic.

Having considered all of these points, I would like all NHS Boards (including NHS Foundation Trusts) to formally publish a statement of readiness against the DH surge and HR guidance at its September meeting. If your Board does not normally meet in September, please arrange for it to do so to consider these important matters. The result of this assessment should be formally recorded for public, patient and stakeholders to see.

Your SHA Flu Lead Director should be able to answer any queries that you might have as a result of this letter. A list of SHA Flu Lead Directors is appended to this letter.

Yours sincerely



Ian Dalton
National Director of NHS flu resilience
Department of Health

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**London Ambulance Service NHS Trust
Winter and Flu Planning Framework 2009/10**


Appendix M

LAS Hospital Diverts and Closures Procedure

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**London Ambulance Service NHS Trust
Winter and Flu Planning Framework 2009/10**

	<p>London Ambulance Service NHS Trust</p> <p>A Pan – London Hospital A&E Queuing, Divert and Closure Policy</p> <p>Circulated To: NHS London For Use By: NHS Acute Trusts, PCT and LAS</p>
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Introduction

As a result of a number of requests to the London Ambulance Service (LAS) for hospital A&E closures or short term divers during the first quarter of 2008 it has been identified that there is a need to agree a pan London Hospital A&E Queuing, Divert and Closure policy. This policy will aim to ensure that Acute Trusts are proactively managing demand and capacity in order to reduce the need to divert patients to alternative services. Diverting or closing hospital A&E can result in increased clinical risk to the patient as well as increased pressure on other local services resulting in increased waiting times in hospital and pre hospital environment.

The aim of this policy is to agree a minimum and comparable data set and the actions that will be delivered should certain, prearranged and agreed, thresholds be met. The data set will be collected regularly from each NHS acute service within the M25 enabling the London health community to anticipate the possible need to divert LAS crews to alternative services to improve the flow of patients minimising clinical risk and waiting times. For Trusts receiving patients from outside the M25 it is the Trusts responsibility to inform the appropriate ambulance control centre if they are requesting a divert in addition to the LAS.

Objectives

- To agree a minimum data set which can proactively be used to manage the demand and capacity of the current Accident and Emergency services served by the London Ambulance Service.
- To agree response levels based on the numerical evidence described above. To describe the arrangements for a conference call between the senior management teams of the acute trusts involved and the London Ambulance Service in order to facilitate multi-sited divers if necessary in order to prevent closure of a department.
- To agree consistency around escalation policies according to an agreed common threshold.

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Winter and Flu Planning Framework 2009/10**

1 A&E Critical Capacity Data Collection

- 1.1 All London A&E's have agreed to provide an agreed a minimum data set which can proactively be used to manage the demand and capacity of the current Accident and Emergency services served by the London Ambulance Service. The London Ambulance Service Emergency Bed Service will be the central collection point for this demand and capacity data, as per the agreed dataset, will be reported at the agreed times: 06:00, 10:00, 14:00, 18:00, 22:00
- 1.2 The following data set has been agreed:
- Patients in A&E Majors (as well as absolute capacity: static info)
 - Patients in A&E Minors (as well as absolute capacity: static info)
 - Patients in A&E Resus (as well as absolute capacity: static info)
 - Patients in A&E Paeds (as well as absolute capacity: static info)
 - Patients in A&E Waiting Area
 - Number of DTA's (Decisions To Admit) who remain unplaced
 - Number of nurses in A&E, predicted and actual
 - Number of doctors in A&E, predicted and actual
 - Waiting time for a doctor in A&E
 - Whether elective surgery has been cancelled or not
 - Number of cardiac beds available in the hospital
 - Number of general beds available in the hospital
 - General comments / free text as appropriate
- 1.3 EBS will provide each A&E with a critical capacity assessment tool (excel spreadsheet) which they are to fill out and email as an attachment to ebs.operations@lond-amb.nhs.uk
- 1.4 This data will support the LAS to proactively identify areas of London that are under pressure and ensure that an LAS manager is despatched to support the departments in resolving the issues, The data will also be used to provide support decision making around agreeing a possible divert.

2 Queuing greater than 15 minutes

- 2.1 In the event that the capacity in an A&E department comes under pressure and patients are queuing to receive treatment it is the Trusts responsibility to attempt to resolve the issues as quickly as possible. This may include arranging a divert with neighbouring Trusts, involving the LAS in these discussions. Any divert agreed must be submitted to LAS by completing the A&E Co-ordination Protocol (Appendix 3) and will require the signatures from receiving hospitals. See section 3.5 for an explanation of need for a triumvirate divert
- 2.2 If, on arriving at an A&E department ambulance staff identify a delay and recognise that they will not be in a position to provide a clinical handover of their patient within 15 minutes (the national DH standard), they should contact the relevant Emergency Operations Centre (EOC) sector desk within LAS to report their delay and inform the lead nurse of the action to be taken. Alternatively if the hospital identify that there will be a delay they too should report this to EOC.

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- 2.3 EOC will document the delay on CTAK (LAS IT system) along with the cause. A Duty Station Officer (DSO) will be dispatched by EOC to the unit to meet with the A&E Management Team and/or the Bed Management Team and to complete a Critical Capacity Assessment (Appendix 2) to enable the EOC Ambulance Operations Manager (AOM) to decide whether further escalation is required.
- 2.4 On receipt of the Critical Capacity Assessment EOC will complete a situation report. The information provided will be added to the daily hospital log. The hospital log will subsequently be shared with commissioners and providers.
- 2.5 If the delay is likely to be over 30 minutes or have an impact on the LAS's ability to maintain an acceptable level of emergency ambulance cover or performance EOC should contact the local AOM or on duty AOM. Discussions between the AOM, Hospital Management Team and Duty manager should agree methods to help resolve the issue, clinical governance and patient safety need to be taken into account. Options to consider include:
- Review with A&E staff if some patients can safely wait in the waiting room
 - Sharing of patients to release crews
 - Utilising LAS A&E support staff to mind patients within the hospital environment
 - Mobilising other clinically trained operational staff i.e. those on alternative duties to help manage the queue
 - Establish patient discharge support requirements and consider utilising urgent care and/or patient transport services
 - Acute Trust should consider arranging a divert with neighbouring Trusts involving the LAS in these discussions. Any divert agreed must be submitted to LAS by completing the A&E Co-ordination Protocol (Appendix 3) and will require the signatures from receiving hospitals. See section 3.5 for an explanation of need for a triumvirate divert
- 2.6 In the event of the need for an internal divert between two sites of the same Trust then a A&E Co-ordination Protocol (Appendix 3) must be completed, including specifying how long the divert is required. However Trusts must be mindful that both sites will still receive some patients as described in section 3.5.
- 2.7 In the event that the queuing situation is unable to be resolved within an hour the on call Director from LAS will be advised of the situation. The on call Director should make contact with Duty Director or Senior Manager for the hospital to determine the long term effect. This should be shared with the on call Executive at NHS London to justify any detrimental impact on daily performance. In addition this information will be shared with the local PCTs to take actions as required (eg working with GPs to control non-urgent demand, and reviewing discharges at their provider services).

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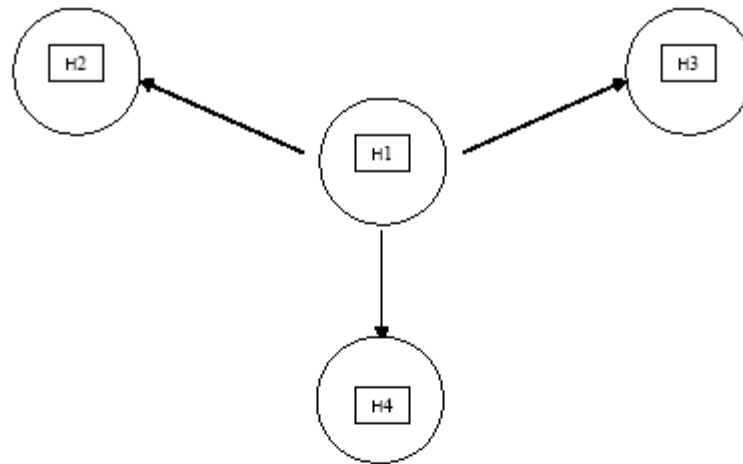
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3 Hospital Divert

- 3.1 Where a hospital starts to come under pressure in its A&E department as evidenced by the returns provided by the Trust to the LAS or where a hospital has three ambulances or more delayed in excess of 45 minutes an initial discussion between the Hospital Director and On Call LAS Director will occur to ascertain if the situation is likely to remain like this, escalate or improve.
- 3.2 Where no improvement in the situation is anticipated following the initial discussion a conference call will be set up, chaired by the On Call LAS Director. The conference call membership will comprise of the nominated On Call LAS Director (chair) along with representation from the hospital under pressure as well as its surrounding three or four neighbouring Trusts. It may include PCT engagement according to the locally agreed escalation policy. It is expected that each Trust will have an escalation policy that notifies their commissioners and the NHS London provider arms.
- 3.3 In this conference call, Director/ On Call Senior Management level representation will be required from the Acute Trusts that surround the Hospital (including those outside the NHS London geographical boundaries where applicable). If the latter is the case the On Call LAS Director will have a discussion with a senior colleague from the local Ambulance Trust so as to keep them informed of the situation and seek assistance in diverting patients to other hospitals in that Trust's operational area if possible. In addition to this, PCT representation for the affected acute trust is required to join the meetings so the community based PCT bed states can be fed in.
- 3.4 At the teleconference the state of each department should be discussed including number of patients in resus, majors and minors along with numbers of patients in the departments and the bed states. Once all units have provided an update a general discussion should occur regarding the provision of support to the unit under the most pressure.
- 3.5 For a hospital to gain maximum respite from a divert it will need to provide the LAS with a minimum of three neighbouring units that have agreed to accept patients on their behalf. If H1 instigates a divert and only gets agreement from H2 and H3 it will still get patients from areas that lie south of the hospital. It would be inappropriate for these patients to be taken past H1 to only be able to access H2 or H3. See diagram and Appendix 1.

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- Once a divert situation has ended the hospital needs to consider repatriation of patients under their care using its own patient transport services.
 - All divers and A&E closures will be reported to local PCTs and pan London Commissioners via agreed reporting mechanisms, including whether or not the policy was appropriately enacted.
- 3.6 If a divert is agreed then the hospital requiring it should undertake the faxes of the appropriate information to all parties involved (Appendix 3). A time frame should also be set for a follow up tele-conference. Faxes should be sent to LAS at 020 7921 5231.
- 3.7 Where LAS have three or more ambulances unable to unload for a period of at least an hour at two adjacent hospitals or where a multi sited divert cannot be facilitated to relieve the pressure the acute unit/s will need to consider closing for a period of time to allow LAS to protect patient safety of those who have dialled 999 and have no support in the pre hospital environment. Where this occurs LAS will either take patients to the next nearest facility or will provide options to manage the situation.
- 3.8 When a follow up meeting occurs the acute unit status should be reviewed and further decisions agreed as to any further support or action to support the Trust/s who are under pressure.
- 3.9 Once the pressure is eased in an acute unit an agreement will be reached that no further teleconferences are required and any escalation or change in the situation will trigger a further meeting.

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4 A& E Closure

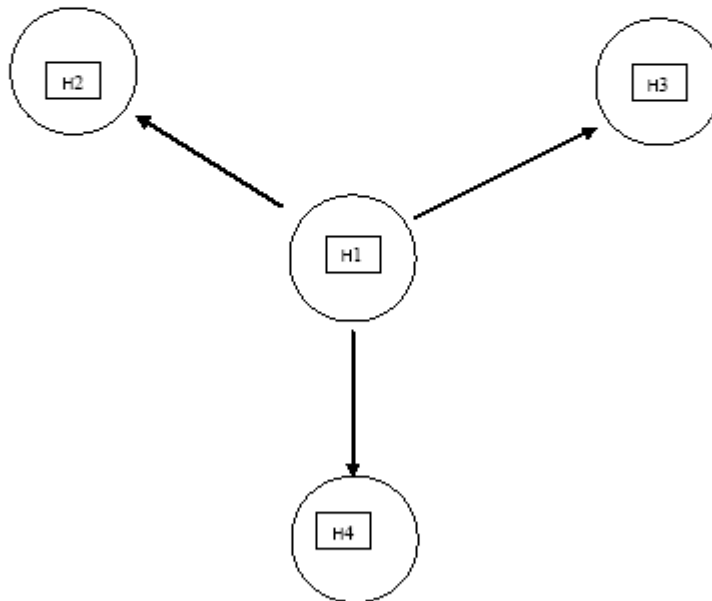
- 4.1 Closure to blue calls will only be accepted in the event that the hospital is not able to provide resuscitation facilities e.g. flood, electrical failure, fire. However, hospitals will be able to close their A&E to all or some of their ambulance calls if they have gained the agreement of their neighbouring units. Closure of a hospital A&E should only be considered as a last resort as it may subject patients to increased clinical risk as a result of travelling further to receive care. GP calls will be expected to be sent directly to ward or outpatients departments rather than via A&E.
- 4.2 In the event that full closure of the A&E department is requested, the same process as diverts should be followed with the exception of the declaration of a major incident. In cases where a Major Incident is declared, and the hospital is unable to keep its A&E department open, then the Hospital will need to declare this to the LAS. Following this declaration no further action will need to be taken by the Acute trust concerned.
- 4.3 The Chief Executive or deputy needs to notify the NHS London On Call Director 01 of their intention to close and the reason and expected duration.
- 4.4 The on call Hospital Director MUST then inform the LAS of the expected timescale of the closure/ next review.

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- EOC should not accept any A&E closure or divert request that is not compliant with the protocol, particularly the principles outlined above. It is the diverting hospital's responsibility to provide details of neighbouring units that have agreed to accept patients on their behalf.
- When a A&E closure or divert request is received and confirmed by fax (not e-mail), (Appendix 3) EOC will check that all the essential details have been filled in, including an authorising officer in every hospital involved and a start and finish time for the divert. ("UFN" is only acceptable for a complete closure). EOC will complete LA10a and inform crews by general broadcast and landline, confirming also when calls are given out. An entry will be made in the EOC OB in red. EOC will inform the Communications department and the on call Gold (LAS).
- The divert will be automatically cancelled by EOC at the notified finish time. EOC will notify crews when the divert is over.

In order for a hospital to gain maximum respite from a divert it will need to provide the LAS with a minimum of three neighbouring units that have agreed to accept patients on their behalf. If H1 instigates a divert and only gets agreement from H2 and H3 it will still get patients from areas that lie south of the hospital. It would be inappropriate for these patients to be taken passed H1 to only be able to access H2 or H3.



- Once a divert situation has ended the hospital needs to consider repatriation of patients under their care using its own patient transport services.
- All divers and A&E closures will be reported to local PCTs and pan London Commissioners via agreed reporting mechanisms, including whether or not the policy was appropriately enacted.

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Appendix 2

.....HOSPITAL (Critical Capacity Assessment Sheet)										
Date of Assessment		/ /			Time:- :					
Resus Room		<small>(INDICATE NUMBER OF PATIENTS WAITING)</small>								
Current Status:-	Full	<input type="checkbox"/>	1/2 Full	<input type="checkbox"/>	1/3 Full	<input type="checkbox"/>	2/3 Full	<input type="checkbox"/>	Empty	<input type="checkbox"/>
Notes:- Waiting Time for Doctor?										
Majors										
Current Status:-	Full	<input type="checkbox"/>	1/2 Full	<input type="checkbox"/>	1/3 Full	<input type="checkbox"/>	2/3 Full	<input type="checkbox"/>	Empty	<input type="checkbox"/>
Notes:- Waiting Time for Doctor? Treatment?										
Minors										
Current Status:-	Full	<input type="checkbox"/>	1/2 Full	<input type="checkbox"/>	1/3 Full	<input type="checkbox"/>	2/3 Full	<input type="checkbox"/>	Empty	<input type="checkbox"/>
Notes:- Waiting Time for Doctor? Treatment?										
Triage Nurse (Waiting Area)										
<small>(INDICATE NUMBER OF PATIENTS WAITING)</small>										
Current Status:-	Full	<input type="checkbox"/>	1/2 Full	<input type="checkbox"/>	1/3 Full	<input type="checkbox"/>	2/3 Full	<input type="checkbox"/>	Empty	<input type="checkbox"/>
Waiting time to see Triage Nurse?										
Notes:- Patients awaiting assessment?										
A & E Staffing Levels				HOSPITAL ALERT STATUS						
		PREDICTED	CURRENT	Elective Surgery Cancelled?		YES	NO			
Nurses:-										
Doctors:-										
Notes:- Expected Increases / Decreases ?										
HOSPITAL BED AVAILABILITY				Name of Bed Manager						
<small>(INDICATE NUMBER OF BEDS)</small>				Phone Number						
ITU	<input type="checkbox"/>	CARDIAC		<input type="checkbox"/>						
HDU	<input type="checkbox"/>	GENERAL		<input type="checkbox"/>						
Infectious Disease in Hospital:	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>						
Notes:- Ongoing / Likely Effects? Ward Closures? Number of Beds Affected?										
LAS Status		Waiting Times		CREWS WAITING FOR						
HANDOVER	<input type="checkbox"/>			HANDOVER		<input type="checkbox"/>				
TROLLEY	<input type="checkbox"/>			TROLLEY		<input type="checkbox"/>				
TOTAL CREWS WAITING AT HOSPITAL										
Notes:-										
Name of Person Contacted in A&E			Phone Number			Form Completed by:-				
THIS FORM MAY BE FAXED PLEASE WRITE CLEARLY IN BLACK INK										
EOC FAX :- 02079215231										
<small>Notes in grey are for guidance and are suggestions for appropriate information</small>										

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Appendix 3

**A&E CO-ORDINATION PROTOCOL
NOTIFICATION OF A&E CLOSURE, AGREED DIVERSION OR ROTA**

FROM:

Name:	Tel:
Position:	Fax:
Hospital:	
Date:	Time:

TO:

Name:	Organisation:	Fax:

EITHER:

This is to confirm that from(time & date)
to..... (time & date)
.....(hospital name) A&E department will be operating/
participating in: (delete as applicable)

(i) An Agreed Diversion, or due to.....

(ii) A Rota, or due to.....

(iii) A Complete A&E Closure due to.....
NHS London on call Director has been notified at.....

I understand that because I have not agreed a divert with all of the
surrounding hospitals some patients will still be conveyed to the diverting unit.

OR:

This is to confirm that as from(time & date) the hospital's A&E
department will resume normal operating, open to all new patients.

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AGREED DIVERSION ACCEPTING UNITS	AUTHORISING OFFICER	
	Name:	Position:
	Name:	Position:
	Name:	Position:
	Name:	Position:
	Name:	Position:

ROTA PARTICIPATING UNITS (AT LEAST 3)	TIME(S) CLOSED (and at the same intervals thereafter)	AUTHORISING OFFICER
1.		Name: Position:
2.		Name: Position:
3.		Name: Position:
4.		Name: Position:
5.		Name: Position:

THIS AGREED DIVERSION OR ROTA APPLIES TO ALL AMBULANCE BORNE PATIENTS EXCEPT:

- (a) BLUE CALLS
- (b) ROUTINE MATERNITY CASES (unless separately specified)
- (c) GP ADMISSIONS PRE-ARRANGED WITH A SPECIFIC HOSPITAL
- (d) PATIENTS DIRECTED TO A SPECIFIC HOSPITAL BY THE EBS

LAS EOC USE: Duty Officer attended: _____ (Call sign) _____ (Time) _____ (Time) LA10d actioned: _____ (Time)

To obtain a revision to this form please contact Sarah Wright, Central Information Unit (CIU), London Ambulance Service
phone: 020 7521 5197 fax: 020 7521 5151 email: ciu@lond-amb.nhs.uk

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Appendix 4

