London Ambulance Service
NHS Trust

Consultation response

June 2013

Dear colleague

I would like to thank all of you who have shared your views on our plans to improve patient care and the working lives of staff under ‘A time for change’.

Many of you have taken the opportunity to voice your concerns on issues, but equally you have shared ideas on how we can improve our Service for both patients and our staff.

We have now considered the responses to the consultation to see where we can make changes to our plans. Within this document we aim to answer some of the key concerns and questions you have raised, and outline where we have adapted our plans.

We are focused on providing our patients with a safe and high-quality service and at the same time reducing the pressure on our staff. What is clear is that we will not achieve this by addressing just one or two of the issues set out within ‘A time for change’. Our proposals set out a range of changes that need to be delivered together.

We will continue to engage directly with staff and the unions to discuss the issues that have been raised, so that we can deliver a package of changes that will improve the service we provide to Londoners.

Ann Radmore
Chief Executive

Background

The Service published its plans to improve patient care and the working lives of staff on 25 April 2013, alongside the announcement that it was to receive an additional investment of £14.8m to implement the changes needed to achieve this.

Staff and initial union consultation on the plans within 'A time for change' ran from 25 April to 24 May 2013.

Details of the plans were made available in a number of ways:

- A Chief Executive bulletin issued to all staff on 25 April announcing the changes.
- All frontline staff received a pack with their payslips containing a document 'Our plans to improve the care we provide to patients' which laid out the plans, as well as copies of the draft policies regarding rest breaks, annual leave and active area cover.
- All the above documents were made available on the intranet, the pulse.
- A Q&A document was also made available on the pulse.
- Six roadshows were held across London where staff were able to hear about the plans and share their views.

Staff were able to provide feedback by:

- completing the hardcopy feedback form within the document 'Our plans to improve the care we provide to patients'
- completing an online feedback form on the pulse
- emailing modernisation@londonambulance.nhs.uk
- attending a roadshow where they could give their views
- providing individual feedback directly to managers.

Responses to the consultation

Responses were received from staff across the Service, with the vast majority coming from frontline staff.

Number of responses received	
Format	**Number**
Online – email	135 (including GMB)
Online - survey	45
Hard copy, using form provided in 'A time for change' booklet	39
Hardcopy - letter	1 (from UNISON)
Verbally at staff roadshows	Over 350 attendees
Total	219 + comments from attendees at staff roadshows

Some of the proposed changes generated more views than others, specifically rest breaks, changes to the frontline workforce, and annual leave.

For each aspect of the change programme, responses were analysed to identify themes in terms of support, concerns, questions and suggestions.

The key findings are given below, with the Service's response as appropriate.

Changes as a whole		
	Key issues	**Service's response**
Support	A number of staff recognise that we need to change how we provide our service to improve patient care.	
Concerns	Staff's main concern is that the changes will not improve things for staff, and there is not enough focus on staff health and wellbeing. Some staff also think the changes are driven predominantly by money.	We strongly believe that by bringing in the proposed changes, as a package, we will see utilisation rates fall. This means staff will be less busy, and there will be less pressure on them. Staff will get a break during their shifts most of the time, and they will also have greater opportunities to increase their clinical skills through better access to training and development. Whilst we are operating in a challenging financial environment, we have received £14.8m funding to

		bring about these changes and improve our Service.
	Some staff feel that the document 'A time for change' is critical of staff, blaming them for current failings.	The 'A time for change' document was written to highlight shortfalls in the service we are able to provide as an organisation – there was no intention to imply any criticism of our staff. Our staff do an excellent job responding to and treating patients, despite increasing demand on our Service. We don't currently provide the level of care that we should to all of our patients, particularly those who do not have life-threatening illnesses or injuries, but we are clear that the reason for this has been underfunding and inefficient working arrangements, not a lack of commitment from our staff.
	Staff also state that the Service should be doing more to address demand.	Like other ambulance services and hospital A&E departments, we are seeing a year-on-year increase in demand. We have started some work to understand what is driving demand in certain areas of London (Croydon and Romford). We cannot address demand on our own, and will be working with other health partners locally to consider ways to tackle the issues identified through this research. The aim will be to share this learning across London in the future. Some work has also been commissioned nationally by ambulance services to look at what is driving demand and NHS England has started a review of emergency and urgent care services, recognising the pressures on the NHS. Some other work we are doing relates to requests received from our biggest single user, the Metropolitan Police Service (MPS). Many of the calls which are sent through to us from the MPS via a computer link do not require an emergency ambulance response. Earlier this year, we piloted the use

		of registered paramedics to review every request, and they were able to re-categorise many of them based on an enhanced clinical assessment. They also had to significantly upgrade some others. If we stopped using the computer link, we would receive 125,000 more calls through the 999 system, so we are focusing on educating the MPS and are looking for additional funding for clinicians who can review their requests.
Questions	Do we understand why people are leaving to work elsewhere, and what are we doing to retain staff?	We have some understanding why people leave our Service, but we are now looking at this in more depth, and will consider what benefits we can provide to staff to improve recruitment and retention. Some student paramedics, once trained, have moved to other ambulance services, often returning home to where their families and friends live. Whilst this has always been the case, we are very keen to retain the staff we have trained. Some services are offering incentives and others have lower utilisation rates. Staff also cite better career opportunities as a reason for moving elsewhere. We aim to make changes so that people choose to stay working with us. Reducing utilisation rates and bringing in a clear structure to help staff develop their clinical skills and progress through the organisation will help with this.
Suggestions	One suggestion to address demand is that more is done to educate the public about the correct use of the ambulance service, and where else they can access healthcare.	Our public education and communications teams continue to educate the public about when to use the ambulance service and the other options available to access healthcare; this is done through school visits and local community events, as well as through the media, campaigns, and social and online media. However, changing people's behaviours is challenging.

		Looking forward, we recognise the need to do more to engage with other parts of the healthcare system to ensure other healthcare options are available and are appropriately publicised.
	A second suggestion, focused on demand management, is to improve the triage and categorisation of 999 calls.	We currently use MPDS to assess and prioritise calls – this is one of two systems currently licensed for use in England. The challenge is that the system is designed to safely identify life-threatening situations very quickly. It imposes strict rules, which we cannot vary from as this would be a breach of the software license and we would no longer be able to use it. By putting additional clinicians in the control room we are able to manage the lower priority calls better with enhanced clinical assessment.
Providing rest breaks		
	Key issues	**Service's response**
Support	A number of staff responded to say that it is in their interest to be given a break during their shift.	
Concerns	The single biggest concern raised during the consultation is that the proposed rest break arrangements will mean staff will not be able to take their break away from their vehicle in a place where they will be safe, have access to facilities and cannot be interrupted by the public.	We acknowledge staff's concerns about where they will be able to take their rest breaks to ensure they get some time away from their work. To address these concerns, one of the things we are considering is swapping the uninterruptible and interruptible elements of the break around. If we did this, the first part of the break (10 or 15 minutes depending on the length of shift) would be paid time which staff could use to find somewhere of their choice to have their break. Although this element of the break is interruptible for Red 1 calls, we would not envisage many breaks being interrupted as we receive only around 40 Red 1 calls a day. The remainder of the break

		(20 or 30 minutes depending on shift length) will be unpaid and uninterruptible.
	Staff are concerned that they will have to use their own unpaid time to drive somewhere to have their break.	As explained above, we are considering swapping the uninterruptible and interruptible time around in the rest break to avoid this.
	Staff are also worried about the loss of the compensatory payment which means they will lose money. Some think that the allocation of time in lieu instead will make it more difficult for staff to take all their leave.	Everybody should be getting a break during their shift, and if someone is getting a compensatory payment under the current arrangements, this means we have failed to give them a break. Staff will have 13 weeks in which to take their accrued compensatory time back and every effort will be made to ensure this is possible; any time in lieu will be used first when an annual leave request is made. The resource centre will monitor the amount of compensatory time accrued and will use the GRS system to ensure that this time is taken within the 13-week period.
	Staff feel that the proposed arrangements will lead to them having more late finishes.	Currently, on average, less than 10 per cent of staff finish their shifts late. We do not believe that the proposed rest break arrangements will see that number increase. In fact, the new roster arrangements and increased staffing levels will reduce the need for staff to work out of their local area, which ultimately will reduce the number of late finishes.
	Some staff state that patients may not receive the care they need if staff are on an uninterruptable break.	The current rest break arrangements include an uninterruptable element, and this will not change.
	UNISON and GMB state that they do not accept or agree the draft rest break arrangements.	The Staff Council and the Joint Secretaries have already begun a series of meetings to discuss issues and concerns raised by both unions. We are clear that staff should get a break during their shift, and that we need to reduce the clinical risk that is posed at shift changeover when

		cover drops.
Questions	Can we carry morphine while we are on our break?	Staff are required to carry the controlled drugs that have been issued to them for their shift on their person while on a rest break. Legislation allows a registered paramedic to have controlled drugs that we have issued to them in their possession both on and off duty. It also directs that controlled drugs must be removed from any vehicle that is not actually operational. Therefore, staff have a legitimate reason to have morphine in their possession whilst on their break.
	When are we supposed to eat?	One part of the rest break will be uninterruptible and staff can use this time to do what they want. It should be noted that the break is a rest break and not a meal break. This is no different to the current arrangements.
	How will we change out of our uniform for our rest break?	Staff do not need to change out of their uniform when taking a break. They should use a jacket or other item of clothing to cover Service insignia/epaulettes if they are taking their break in a public place. This is no different to the current arrangements.
	Are crews covered for insurance purposes to drive a Service vehicle while on an unpaid uninterruptable break?	Yes, staff are insured to drive a Service vehicle during their rest break, provided they follow policy.
Suggestions	Staff suggest that the interruptible and uninterruptible periods of the break are changed around.	We are considering the suggestion that the uninterruptible and interruptible elements of the break are swapped around. We believe this could help address staff's concerns about being able to take a rest break which gives them time away from their work. This would mean that the first part of the break (10 or 15 minutes depending on length of shift) would be paid time which staff could use to find somewhere of their choice to take their break.

		Although this element of the break is interruptible for Red 1 calls, we do not envisage many breaks being interrupted as we receive only around 40 Red 1 calls a day. The remainder of the break (20 or 30 minutes depending on shift length) would be unpaid and uninterruptible.
	It is suggested that staff should be sent to the nearest ambulance station, or hospital, for their break.	Under the European Working Time Directive staff are entitled to a break if they work more than six hours, although national terms and conditions recognise that for ambulance staff this may not always be possible. There is no requirement for a rest break to be allocated or taken at a specific location. If we decide to swap the uninterruptible and interruptible elements of the break around, staff will be able to use the first 10 or 15 minutes of paid time to travel to a location of their choice. Once on a break, staff can spend the time in whatever way they wish, and wherever they wish, provided that they are ready and available for work at the end of the period.
	One suggestion is that arrangements are put in place to ensure crews are returned to their station by the end of their shift.	Crews need to remain available to respond for the duration of their shift. Looking forward, if we plan our resources better and introduce staggered rosters, we are confident this will reduce the number of times that staff finish their shifts late.
	A request was made by some staff that VOR (now 'out of service) should not be considered as a rest break.	If it is known that there will be sufficient time for a break when a crew is taken out of service, they will be allocated a break at this point, rather than wait until the crew are available for work again and then put them on a rest break.

Adapting our frontline workforce		
	Key issues	**Service's response**
Support	Those staff who supported the proposed changes to the make-up of the frontline workforce state that they welcome A&E support staff working alongside a paramedic and think it is a sensible approach. UNISON supports the principle of A&E support staff working with a registered paramedic, but not as proposed within 'A time for change'.	We will continue to engage with the unions on our proposals.
Concerns	The main concern raised in relation to these proposals is the banding of the A&E support staff who would work alongside a paramedic in future, attending all types of emergency calls. The findings of a survey of A&E support staff, presented to the Executive Management Team during the consultation, showed that 94 per cent of respondents* agreed with the statement that the future A&E support role should be paid at Band 4. The current role is paid at Band 3. This was supported in other responses to the consultation. UNISON wants to see A&E support staff performing a band 4 technician role. GMB fully supports the development of A&E support staff, which means them being fully trained and performing a band 4 role. *100 people responded to the A&E support staff survey.	The A&E support staff role will be assessed through the national Agenda for Change process. This is a jointly agreed national process which measures the scope and demands of a role across a number of factors, including physical effort, knowledge training and experience, and autonomy to act independently. Simply altering a role or taking on a different range of tasks does not necessarily lead to a change in pay band. At this stage, however, as explained at the roadshows, we anticipate that the process will confirm the A&E support role at band 3.
	Some respondents stated that this model has not necessarily worked elsewhere and don't feel it is the	This model is used in a number of ambulance services. We believe this is the best option to enable us

	best model for London. UNISON does not agree that this is a nationally accepted model of care, and does not believe it is in the best interests of the Service and Londoners. GMB sees the proposed changes as a major change for members and does not believe they are in the best interests of the Service or the public of London.	to move to a paramedic-led service which will see more patients being overseen by a registered health professional, which is in line with the recently published Francis report.
	Some staff, predominantly paramedics, stated that working alongside A&E support will increase the pressure on paramedics and will leave them less supported.	There is no evidence of this from ambulance services that have been operating this model for some years. A&E support staff will have the necessary training and skills to support paramedics. Additionally, one of the benefits of the new career structure means that there will be a lot more clinical supervision. We have the clinical support desk already, but more clinical support in the field will be really important in the future.
	UNISON and GMB do not believe that six days' extra training will give staff the skills or confidence to attend all potential calls.	We are confident that the planned training programme will provide A&E support staff with the additional skills they need to work alongside a paramedic attending to all types of emergency calls. This course was run in May 2012 and the feedback supported this.
	UNISON and GMB also state that this is a 'down banding' or 'de-skilling' of the technician role.	These changes will not see us 'de-skilling' the emergency medical technician role. This is a post and grade that is already closed in the Service, and there has been no recruitment of technicians for some years. In addition, we are looking at opportunities for technicians who want to progress to paramedic level.
Questions	Can you confirm what band the A&E support staff will be paid at in the new model?	The role will be assessed through the Agenda for Change process; however, as explained above, we anticipate that it will be confirmed at band 3.

	What will the A&E support staff training involve when the role changes? The timeframe says that A&E support staff will start working with paramedics between July and September – is this right? And will existing A&E support staff be trained before new recruits?	Existing A&E support staff will attend a six-day training programme which will include awareness of: • London Underground trackside safety and extrication • trauma assessment, c-spine immobilisation, splinting, helmet removal and scene safety • paediatric clinical assessment including identifying the sick child • paediatric and neo-natal resuscitation • overview of maternity care and maternity emergencies • supporting a paramedic during the management of a cardiac arrest in a capacity the lead clinician deems appropriate. The additional training for existing A&E support staff is planned to start in August, with the aim that it is completed before new recruits finish their training.
	Where does the new model leave duty station officers who are technicians? Will they be excluded from responding to calls as single responders?	This is an issue that needs to be looked at more closely and worked through with those affected. The DSO role is primarily about managing incidents and giving support to staff; they are only used to answer calls due to high levels of demand and this will change in the future as more staff are recruited. During the transition period, they will continue to respond as they do now.
	What is the future for emergency medical technicians?	We have not recruited to the role of emergency medical technician for a number of years. Looking ahead, there will be opportunities available for technicians to progress to become paramedics. If they do not wish to become a paramedic, then they will be able to continue working within their current scope of practice but this will eventually be on ambulances only. It will take some time for us to recruit sufficient

		paramedics to undertake all solo response roles, and in the meantime emergency medical technicians will continue in these roles.
Suggestions	A suggestion was made that the transition to this new model would be easier if paramedics and A&E support were permanent crew mates.	The intention is that whilst there will be occasions when staff will have to work with someone else (for example, to cover leave), the majority of staff will work on a fixed line with a regular crew mate. We currently have 280 A&E Support staff and the expectation is that the majority, if not all, will be accommodated on new rosters once they are worked up. New recruits are likely to work under new, more flexible, relief arrangements, with a transfer register in place.
Changing annual leave arrangements		
	Key issues	**Service's response**
Support	No themes identified.	
Concerns	The main concern about the proposed annual leave arrangements is that staff think it will be harder to take leave, particularly during school holidays.	It is apparent from speaking to staff that the proposed annual leave arrangements are not clear. We will therefore revisit them and ensure they are written so that staff are clear exactly how annual leave will be allocated. We will also provide some examples to illustrate how the arrangements will be applied in different circumstances. Regarding staff's main concern that it will be harder to take leave, the proposed arrangements will enable staff to take all their leave during the year; however, as with the current arrangements, staff may not always get leave when they want it. It is important that we maintain the right mix of staff on duty ie in future that will mean a paramedic and A&E support/emergency medical technician on an ambulance.

	Staff feel that it is unfair to refuse leave on bank holidays. And they do not want to be forced to take leave when they don't want it.	It was never the intention to suggest that no-one could be off work on a bank holiday. Based on staff's concerns, this is one of the key areas that we need to clarify and explain. Essentially, requests for leave on bank holidays will be considered in the same way as requests for leave on any other days.
	Some staff feel that it is unreasonable to include abstractions in the calculation for annual leave allocation, as staff have no control over these.	Abstractions are not included in the calculation for annual leave. A percentage of the hours produced by staff will be allocated for annual leave. Abstractions will be on top of this and if for any reason the level of abstractions is higher than it should be, this will not affect the annual leave allocation.
	The proposed two weeks' notice period is regarded as too much.	The reason we request two weeks' notice for annual leave is to enable us to plan effectively so we have the level of cover we need to maintain levels of service. If less than two weeks' notice is given, the request cannot be automatically granted by the resource centre and will have to be considered by the duty management team. Ad-hoc or short notice leave remains possible in some circumstances, but should not be the norm.
	UNISON and GMB do not accept or agree the draft annual leave arrangements.	We will discuss the details of the proposed annual leave arrangements with the joint secretaries, with a view to establishing a group or forum to review the arrangements. Our aim is to provide an approach to annual leave that gives staff access to their leave while also achieving a fair distribution, and one that protects cover and ultimately patient care whilst also ensuring that all leave can be taken within the annual leave year. We need to move to a position where carrying over leave is the

		exception, not the norm.
Questions	How will I get leave during the school holidays?	Staff should apply for annual leave during the school holidays as they do now.
	Why are bank holidays treated differently?	It was never the intention to suggest that no-one could be off work on a bank holiday. To clarify, requests for leave on bank holidays will be considered in the same way as requests for leave on any other days.
Suggestions	A suggestion was made that the Service employs more staff and ensures the relief factor is adequate, so that staff can take leave when they want it.	We have received additional funding to increase staffing levels through this year which will provide more cover, and should ultimately mean it is easier for staff to take their leave.
Introducing a clinical career structure		
	Key issues	**Service's response**
Support	Staff were pleased to learn that a clinical career structure is being developed, with some feeling it is long overdue.	
Concerns	Based on previous experience, some staff do not believe the clinical career structure will be delivered.	We are committed to providing staff with a clear clinical career structure that enables staff to develop their clinical skills and progress their career within our Service. So far, we have completed the first recruitment round of clinical team lead (hub) paramedics as well as the training course for these staff. We have scoped the team leader update course which is planned to start in the autumn.
	Emergency medical technicians want to know what opportunities there will be for them to up-skill to become a paramedic, if they cannot go to university.	We are considering restarting the in-house IHCD programme which will enable emergency medical technicians to train to become paramedics. The HCPC has confirmed that we can provide these courses, but we now have to work through the cost implications. Anyone who meets the pre-entry assessment and can complete all the elements of the programme (some of which are physical skill elements), as well as undertake

		frontline duties on an ambulance, can complete the internal IHCD programme.
Questions	How can you progress to the advanced roles within the proposed structure? Will you need a degree?	In the longer term, staff who want to move up the clinical career structure will need to think about an academic route, and gain a wide range of experience in different clinical roles. In the short term, if staff do not have the academic qualifications, we will assess if what they have done could, or is, deemed to be the equivalent.
	What training will be offered, and will it be funded?	The current arrangements with St Georges and the Open University require staff to pay their own fees. If we restart it, the internal IHCD course is likely to be funded.
	Will there be an internal route for emergency medical technicians to progress to paramedic?	We are considering restarting the in-house IHCD programme which will enable emergency medical technicians to train to become paramedics. The HCPC has confirmed that we can provide these courses, but we now have to work through the cost implications. Anyone who meets the pre-entry assessment and can complete all the elements of the programme (some of which are physical skill elements), as well as undertake frontline duties on an ambulance, can complete the internal IHCD programme.
Suggestions	It is suggested that there should be some non university options for staff who want to progress.	See the answer to the question above.
Aligning rosters with demand		
	Key issues	**Service's response**
Support	Some staff responded saying that changing the rosters was a necessary exercise.	
Concerns	One of the main concerns about changing rosters is that shifts shorter than 12 hours will increase travel costs.	There is a possibility that this could happen. The core rosters will be designed to meet the needs of our patients and provide sufficient cover at the times that the public use our

		Service.
	There is a concern that revised rosters could impact on family life, and staff are keen that future rosters are flexible and family friendly.	The rosters will be designed locally with staff, and we will maintain staff friendly rosters in circumstances where the requirements of the policy are met.
	It is also felt that the current B relief arrangements are unfair.	The A and B relief roster will be removed as part of this process.
	Staff expressed concern that protected training days are disregarded due to demand, and that this will happen in future.	We will be introducing individual learning accounts through which all operational staff will be able to manage their training. The hours produced by the roster will exclude these training hours. This means that staff will not have designated training days within their projected work time, but will book their training on non-rostered days to make up their full contracted hours. This is outside of identified cover.
Questions	Why are we using an external company to develop the new rosters when this will be expensive and could be done locally?	Last time we reviewed the rosters we did it in-house and it didn't work efficiently. It took too long to design the different patterns and receive feedback. This is why we have opted for a specialist company to help us. This company has specialist software which helps to design rosters to fit demand patterns, which is exactly what we need, as demand on our Service changes depending on the time of year as well as the time of day. Importantly, there will be a lot of input from staff in this process, and the review will be in line with the jointly agreed process for changing shift patterns. This work will start in mid August.
	Are there any plans for training before the individual learning accounts are introduced, eg JRCALC guidelines training?	The new core skills refresher courses that include an update on the UK clinical practice guidelines have started, with 90 places per week being provided.
Suggestions	It is suggested that more should be done to place staff on stations near to where they live, or to give them the option to choose which station	We will do our best to place staff on stations where they would prefer to work, but we will have to balance this with the need to provide the

	they are based at.	appropriate levels of cover to support the delivery of patient care.
	Staff also suggested that all core lines should be filled.	By increasing staffing numbers and bringing in the other proposed changes, we will eventually fill all core lines.
	GMB stated that the changes to rosters should be dealt with under the jointly agreed framework.	We have always said that we will use the jointly agreed framework to develop the rosters.
Responding differently to patients		
	Key issues	**Service's response**
Support	No themes identified.	
Concerns	It is felt that frontline staff and telephone advisers will need more training to be able to respond as outlined in the proposals.	Clinical team leaders on the road and in the clinical hub will provide support to frontline staff. And the individual learning accounts that we are introducing will provide operational staff with better access to training and development, which will increase their confidence in responding differently. A separate consultation is taking place with clinical telephone advisers and any training needs will be identified through this.
Questions	Will we use less private ambulance crews in future?	Yes. During peak times when we have 300 ambulance crews on duty, around 25 of these are from private or voluntary ambulance services and mainly work the shifts our staff are not keen to – 15.00hrs to 03.00 hrs. We want to move away from using private companies as part of our regular fleet and as staff numbers increase we will work towards doing this.
	How are we working with partners, specifically GPs to reduce demand?	We have started some work to understand what is driving demand in certain areas of London (Croydon and Romford), and will be working with other health partners locally, including GPs, to consider ways to tackle the issues identified through this research. The aim will be to

		share this learning across London in the future. In addition, we have monthly meetings with our commissioners to share feedback. And our senior managers and community involvement officers are increasingly engaging with local urgent care boards.
Suggestions	Staff suggested that 111 calls need to be assessed better.	Our 999 call prioritisation system, MPDS, is a rapid triage system aimed at identifying life-threatening calls quickly. 111 uses a clinical assessment system (similar to that used by our clinical telephone advice team) to provide more detailed assessment. We are currently finding that calls that come to us from 111 providers have very high conveyance rates. The problems seem to be more anecdotal than evidence based, but we are watching this very carefully and meet with the 111 providers on a monthly basis.
Extending the use of active area cover		
	Key issues	**Service's response**
Support	No themes identified.	
Concerns	The main concern voiced by staff is that the proposed active area cover arrangements will mean staff are not able to spend downtime on station to catch up on updates or de-stress after busy jobs. It was also stated that team leaders will not be able to use this time to support staff.	Active area cover enables us to provide a better service to patients because it places our staff closer to incidents and helps reduce the time it takes for us to reach patients. Not all staff will be providing active area cover at any one time, which means staff will still get opportunities to use downtime to de-stress or for developmental purposes.
	Staff feel the proposals are unsafe and do not support staff wellbeing.	We take staff safety seriously and these arrangements have been subject to a formal risk assessment. However, staff should also carry out their own risk assessment when on location. If they are going to stay in the same place and not patrol, they

		should think for example about parking in a safe area, with good lighting, CCTV coverage and radio and mobile telephone signal. Staff can patrol within a half mile radius of the cover point they are allocated and therefore should be able to move around and position themselves in a safe location.
	Some staff think that demand is too high for active area cover to be used.	By bringing in the proposed changes, utilisation rates are expected to fall by an average of 10 per cent, which will enable us to use active area cover more effectively.
	UNISON and GMB do not accept or agree the draft active area cover arrangements. UNISON opposes the arrangements because it feels they impact on the health and safety of staff. It is also concerned that the importance of ambulance stations as a place for lowering stress and increasing the health and well being of staff is being marginalised.	We will continue to meet with the unions to discuss the concerns they have raised.
Questions	Why do we need to provide active area cover on a 24/7 basis when we already provide a good response to Category A patients?	Whilst we provide a good service to Category A patients, many of our other patients receive a poor service. We know that our performance drops across the day and we must make improvements so that we provide a more equitable service 24/7. Extending active area cover will help us achieve this.
Suggestions	No themes identified.	
Increasing vehicle availability		
	Key issues	**Service's response**
Support	No themes identified.	Little feedback was received regarding our plans to increase vehicle availability. Therefore, as the proposed changes will benefit staff, we have decided to take this work forward, and at the beginning of June we launched a single point

		of contact for all vehicle availability issues for the East area. This will be extended to the rest of the Service over the summer.
Concerns	No themes identified.	
Questions	No themes identified.	
Suggestions	No themes identified.	

A number of other issues were raised by staff responding to the consultation.

Concerns were raised regarding:

- **missing and damaged equipment**

  We have a new contract for vehicle preparation and ambulance operations managers are now able to monitor local performance by the contractor and address any shortfalls in the service that is provided. We have also introduced an asset tracking system which helps us track the movement of key items such as LifePaks and carry chairs.

  We will shortly be issuing a policy which will define what constitutes personal issue equipment and outlines staff's responsibilities if they are provided with equipment on this basis. The policy will also outline how we manage the loss and damage of equipment that is provided as personal issue.

- **the poor state of ambulances**

  We have agreed a two-year vehicle replacement programme; this will see approximately 100 new ambulances delivered over the next two years, and the oldest ambulances will be withdrawn. We also need staff to take more responsibility for the state of our ambulances, as well as equipment.

The following suggestions were also made:

- **reduce the 'them' and 'us' culture between staff and management**

  We recognise that there could be more interaction between staff and all levels of management. We are currently looking at ways of improving that interaction in both a formal way (for example, roadshows, briefings) and informal ways (for example, managers undertaking rideouts more frequently).

- **consider personal issue of diagnostic equipment**

  We are considering personal issue for some diagnostic equipment. A register will clarify what equipment will be provided as personal issue, for example, BM kits and tympanic thermometers. Pulse oximeters would be too expensive to provide as personal issue, and they would not work for paediatric cases. Instead, we plan to put them in bright yellow bags on ambulances, which can be asset tracked.

We will shortly be issuing a policy which will define what constitutes personal issue equipment and outlines staff's responsibilities if they are provided with equipment on this basis.

Next steps

There are a number of issues highlighted through the consultation which we need to give further consideration to.

We will continue to engage with staff and the unions on areas of concern, and we plan to hold some more roadshows in the middle of July where staff will be able to hear firsthand about progress. We will advertise details of these shortly.