London Ambulance Service
NHS Trust

LAS 999 Winter Plan 2024/25
18 November 2024 – 31 January 2025

Final version – signed off at pan-London UEC Board meeting on 11/11/24

We are the capital's emergency and urgent care responders

Introduction

- So far this year at the LAS, we are receiving 9% more 999 calls per day.
- If this trend continues, we expect to see a category 2 response time this December of 57 minutes and 10 seconds.
- That will mean there would be days where the mean response time will be over an hour. This will severely compromise patient safety.
- This winter plan mitigates risk to patients in the community. It outlines as a London wide system how we will work collaboratively to share some of the risk.
- We will monitor the impact of this plan in early December, January and February and then carry out a pan-London review involving the ICSs and Region to inform the plan for 25/26

The structure of this document:

- **Winter baseline actions**
- **Patient flow framework**
- **Escalation framework**

Implementing this plan requires the London system to agree the following actions:

1. **Baseline winter operating level**
   - 1A Agree patient groups where LAS can refer direct to GP (slide 9 & 10)
   - 1B Agree new fit to sit criteria (slide 11)
   - 1C Agree simplified LAS cohorting (slide 12)
   - 1D Agree to treat LAS as a "Trusted Assessor" for referral pathways (slide 13)
2. **Patient flow framework**
   - 2A Agree the 6 steps in the framework (slides 14 – 22)
   - 2B Agree the blue light redirect process (slide 15)
   - 2C Agree which patients will continue to be conveyed to a hospital when framework is operational (slide 23)
3. **Escalation level actions**
   - 3A Agree there will be two new escalation levels, Red and Purple – requiring agreement and action by the system (slide 26 & 27)
   - 3B Agree that at Orange, LAS can use a focused clinical record when conveying patients to hospital and providers will accept referrals from clinicians not on scene with the patient (slides 28-31)
   - 3C Agree that at Blue level hospitals will complete patient handover at 45 minutes without exception (slides 32)
   - 3D Agree that Red will be ICS specific, with jointly agreed actions which may include completing the patient handover at 30 minutes (slide 33)
   - 3E Agree that Purple actions will apply pan-London (slide 35)

Winter baseline actions

LAS baseline winter actions

Applicable at all times, irrespective of escalation level

- Increased operational staffing in line with expected increase in demand
- Winter delivery cell 7 days per week
- Maximised 999 'hear and treat'
- Specific referrals to GPs from LAS (as agreed through consultation with pan-London LMC)
- Maximised 'Fit to Sit' for suitable patients
- Earlier and simpler process to implement LAS cohorting
- Trusted assessor to access alternative pathways e.g. SDEC
- Ensure 999 does not impact on 111 service delivery

Increased operational hours

- Double Crewed A&E Ambulances
  - Weekdays – from 6300 hours to 7200 hours
  - Weekends – from 6000 hours to 6800 hours

- 999 Call Handling
  - Weekdays – from 1600 hours to 1775 hours
  - Weekends – from 1600 hours to 1800 hours

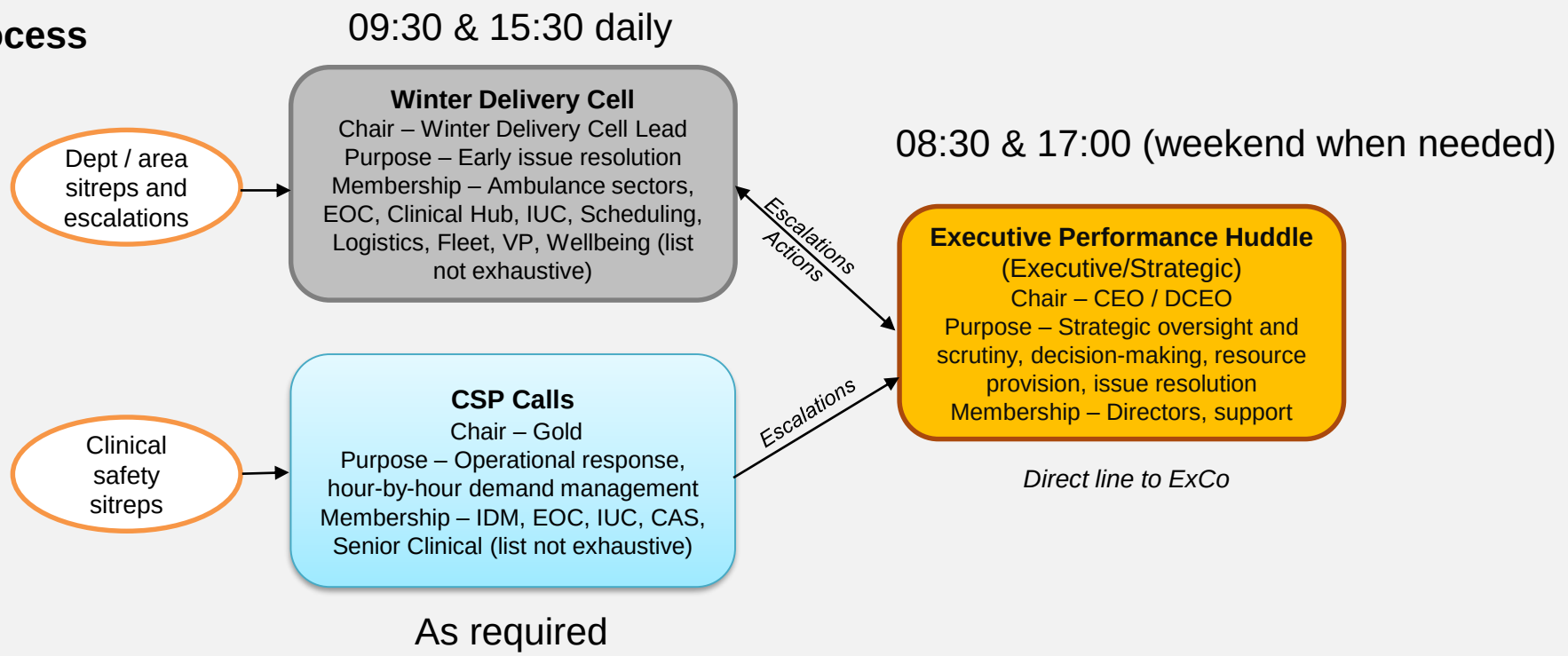
Increased hours will be achieved through focused use of overtime as part of agreed financial plan.

Winter Delivery Cell

A tactical **winter delivery cell** in LAS, operating **7 days per week**

The tactical level Winter Delivery Cell will bring together operational directorates and support services to raise and resolve short-term logistics and staffing issues close to source, escalating concerns to the daily Executive Performance Huddle. Issues typically resolved by the Winter Delivery Cell include equipment distribution issues and the sources of OOS. The Winter Delivery Cell supports the work of the IDM and Tactical Operations Centre, which are focused on the immediate day's delivery.

Winter Escalation Process



Maximising 999 Hear and Treat

We will consistently implement our new clinical dispatch model which ensures maximum clinical input into Category 2 segmentation, referral to alternative clinical pathways and clinician oversight of ambulance dispatch to deliver a consistent Hear and Treat rate above 20%

Reducing impact on primary care –

London-wide LMCs have requested LAS to only refer in specific circumstances

- LAS crews to only contact GPs for the following patients:

  - End of Life Care
  - Safeguarding Concerns where background / history would support decision making
  - Notification of an Expected Death
  - HCP Admission Call where an alternative management plan / community team referral may be more appropriate

LAS clinicians will refer a smaller cohort of patients directly to their own GP

This was co-designed at the request of the pan-London LMC

- To obtain baseline / clinical information, not available on LCR / UPC / NCRS	Contact – Patient's **own / registered GP reception team** – no need for clinician / clinician discussion
- Complex / Vulnerable Patients - Clinical discussion to prevent admission / conveyance - Shared Decision making - Urgent Medication Request - Paediatric patients where the patient may be discharged on scene	Contact - **111*5** to speak to a GP Contact - **Clinical Hub** to speak to Paramedic, MH Nurse
- Further assessment /follow-up needed, but no conveyance required - Repeat prescription requests	Encourage **patient to contact registered GP** If unable, crew to contact 111*5 or registered GP on their behalf to request follow-up
- Information sharing only – NO action / immediate request required	**Complete EPCR** **Complete MS Form** to share attendance information

Fit to Sit

A new guide to maximising patients who are **Fit to Sit** (based on learning from models used elsewhere)

Patients are "Fit to Sit" if they are:

Fit to Sit in ED waiting room

Patients who are stable and do not require ongoing observation

- Able to self-mobilise or sit in a wheelchair without concerns
- If the patient is normally dependent on carers, support is present
- 10 mins has passed since the last administration of any medication or 20mins since the administration of opioids or benzodiazepines
- No apparent risk of falls, no safeguarding concerns

Fit to Sit in ED where patient can be observed by a clinician

- The GCS is 15 on arrival at hospital and has been for the previous 30 minutes (for patients where GCS was reduced initially)
- The NEWS2 score is <5 on arrival at hospital and for the previous 30 minutes
- Where a patient would otherwise be Fit to Sit, but for another risk such as self-harm or absconding.

For all patients arriving at ED consider direct access to alternative destinations in the hospital e.g. SDEC, UTC, MAU/SAU, Injuries area, EPU.

LAS Led Cohorting

LAS Led Cohorting is now a **tactical option for use by the Incident & Delivery Manager (IDM) at any time**, regardless of a receiving hospital's designated Patient Flow Framework level to support when pressure is building

Cohorting can be implemented when:

- **The hospital Trust request it, due to 2 x LAS crews are waiting for 15 minutes or more**
  The affected hospital can make a request to LAS via SCC (or via the Senior Manager On Call where different OOH arrangements are in place). The IDM will review the request providing space and trolley beds are available.
- **The LAS Duty IDM deems it appropriate** to implement LAS Led Cohorting due to delays at hospital and number of patients waiting in the community for an ambulance; the IDM will liaise with the SCC in implementing
- **The hospital Trust have made every attempt to provide nurse led cohorting** and makes request to SCC who confirms that space/trolley beds are available

IDM authorisation will be for 1 to 4 hours maximum
If still required after 4 hours, either LAS or the Hospital Trust will request an extension via the relevant SCC. If any party does not agree with the request then we require a system call including ICS Silver, LAS IDM and Hospital Trust Silver. Clinical support to the discussion should be requested if needed. The call should be convened prior to cessation of cohorting.

The LAS will run cohorts in partnership with other NHS Ambulance Services where applicable

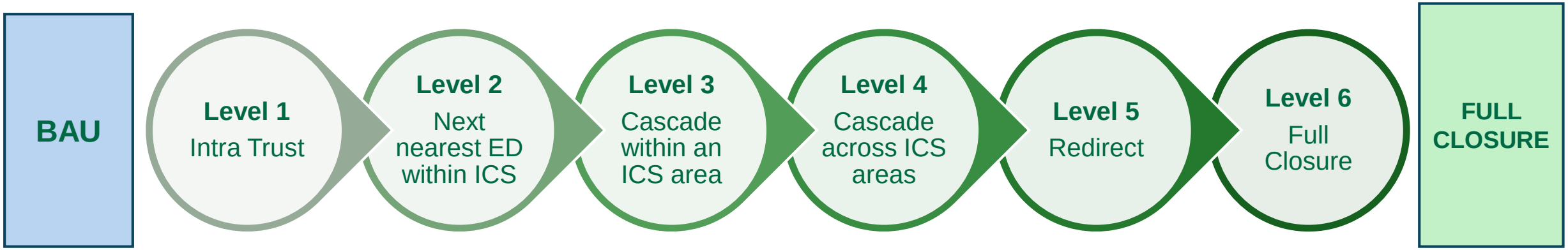
Trusted Assessor

- Designate LAS a "Trusted Assessor" for UTC, SDEC, MH units and UCR
- This means LAS referrals can be accepted without review from a clinician from the accepting service, because the LAS clinician is trusted to assess patient suitability

Patient Flow Framework

Patient Flow Framework

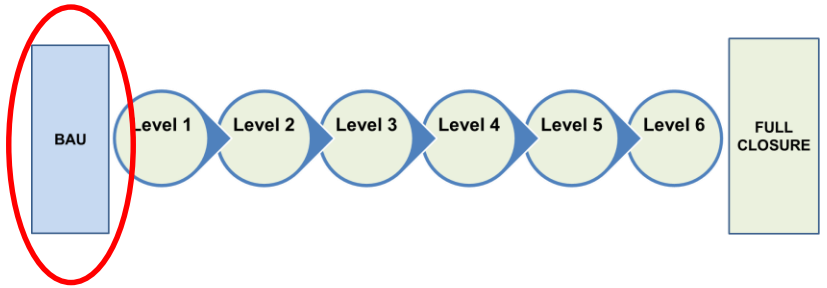
Escalation Ladder summary – **See following slides for detail**



- Note: Demand and risk assessment inform the level. Progression through levels is not linear (i.e. it is possible to move from BAU to any level straight away if the situation on the ground requires it)
- LAS authorised Blue Light Redirects – where a high number of pre-alerts have been placed to one unit, will be treated as BAU and managed by the Duty IDM (EDs - 5 Blue calls in 90 minutes *OR* large ED (including MTC or other tertiary centres e.g. HASU, MTC – 7 Blue calls in 90 minutes).
- Trusts cannot request blue light redirects for Resus exit block.

Patient Flow Framework

Business As Usual



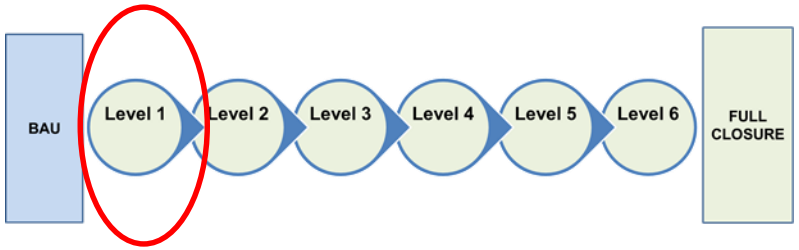
BAU options available to manage flow:

- BAU – Conveyance to the nearest hospital if the tertiary centre guidelines not met
- Patient flow utilising the pre-agreed catchment area postcodes
- Up to 45min patient handover at hospitals (target <15 mins)
- Fit to sit applies (please see Fit to Sit criteria for the definition to avoid variation of understanding)
- LAS-led cohorting (see details on LAS Led Cohorting slide)
- Blue Light Redirects – where a high number of pre-alerts have been placed to one unit, blue light redirect will be treated as BAU and managed by the Duty IDM (EDs - 5 Blue calls in 90 minutes *OR* large ED including MTC or other tertiary centres e.g. HASU, MTC – 7 Blue calls in 90 minutes). Trusts cannot request blue light redirects for Resus exit block.

BAU Authorisation required:
LAS Led Cohorting needs to be authorised by the IDM

Patient Flow Framework

Level 1 – Intra Trust



Level 1 Options available to manage flow:
Exclusions to Compromised ED (see exclusions slide)

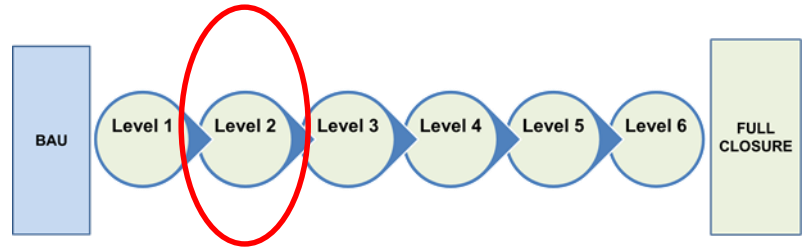
Level 1 Authorisation required:

Trust Informs SCC/SCC on call out of hours. Where SCCs have different out of hours arrangements, the SMOC (Senior Manager on call) will contact LAS.

Authorised by Duty IDM or their appropriate delegate (e.g. ODM) – Review at 90 minutes.

Patient Flow Framework

Level 2 – Next nearest ED within ICS



Enhanced Patient Flow arrangements

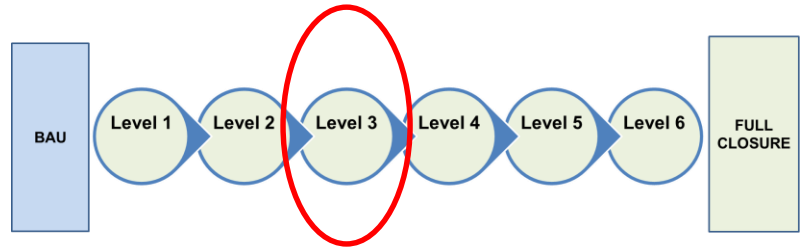
Level 2 Options available to manage flow:
Exclusions to compromised ED (see exclusions slide)

Level 2 Authorisation required:

- Duty ODM can implement for 1 hour if there have been an extraordinary amount of ambulance conveyances within a short time frame of which bottlenecks are likely to occur
- Duty ODM to inform SCC post implementation (22:00 to 08:00 via email)
- Trusts can request Level 2 via the SCCs/on call
- Where different arrangements exists for out of hours, request to come from the SMOC providing they have spoken with the affected trusts who confirm they are able to support

Patient Flow Framework

Level 3 – Cascade within an ICS



Level 3 Options available to manage flow:

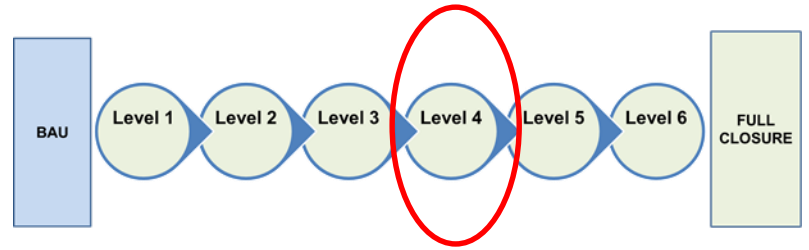
- A: Pre-Agreed postcode redistribution (Exclusions go to compromised ED)
- B: Utilising all or selected hospitals within the sector (Exclusions go to compromised ED)

Level 3 Authorisation required:

- Duty IDM Authorisation following request from SCC,SCC/ICB on call. System Call to be convened unless the SCC/ICB representative has live time up to date information and suggests to the Duty IDM that this is implemented.
- SMOC from each ED Trust (including Gold of affected trust) LAS Duty IDM, Senior Clinical on call, SCC/ICB Gold to join the call.

Patient Flow Framework

Level 4 – Cascade divert across an ICS area



Redistributing to other ICS sectors (domino divert)

Level 4 Options available to manage flow:

- Implemented when all EDs within sector/ICB region are compromised, with a significant number of ambulances waiting with patients, with no plans to offload.
- Level 4 is designed to dynamically redistribute patients across sector and ICB boundaries which will involve patient displacement.

The impact to receiving hospitals and LAS resource availability will be significant and will require an incident response from the LAS.

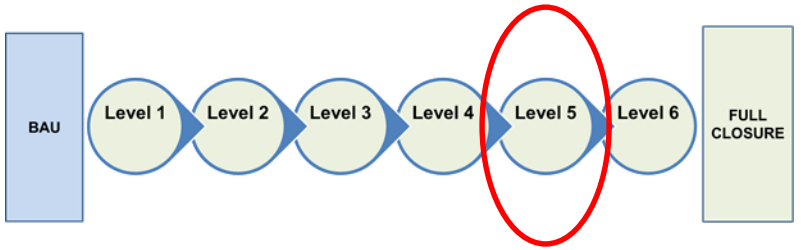
Level 4 Authorisation required:

- Chaired by NHSE London Gold/Silver, attendance from LAS Gold, IDM, affected ED Trust Gold/Silver, affected ICS Gold/Silver, affected LAS ICS ADO, LAS SMA / senior clinical on call.

Patient Flow Framework

Level 5 – Redirect

Blue calls and specialities only to compromised ED



Level 5 Options available to manage flow:

A: Intra Trust: Only blue calls and specialities (HASU/Maternity/HAC/MTC) to compromised ED

B: Using non Intra Trusts: Only blue calls and specialities (HASU/Maternity/HAC/MTC) to compromised ED

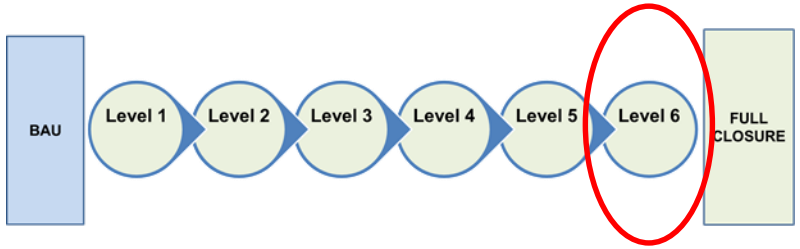
Level 5 Authorisation required:

A: Duty IDM authorisation following discussion with Senior Clinical on call or SMA

B: System call required. Gold/Silver from each ED Trust, LAS Duty IDM, Senior Clinical on call/SMA, SCC/ICB on call and ICS Gold (for all affected ICS)

Patient Flow Framework

Level 6A and 6B – Full closure



(Including EDs accepting tertiary patients, e.g. HASU, MTC**)**

Level 6 Options available to manage flow:
ED unable to treat patients safely.
All conveyances to be directed to next nearest appropriate ED.

Level 6A:
ED Closure
Level 6B:
Hospital closure including tertiary centre

Level 6 Authorisation required:
Initial authorisation by Duty IDM followed by Gold Call. This decision is taken when there is:

- Infrastructure failure
- Flood
- Fire

Call required including SMOC and Gold of affected trust, LAS Duty IDM, LAS Strategic Medical Advisor, SCC/ICB Gold, NHSE London Gold/Silver.

Patients who will still be conveyed to the nearest ED in Patient Flow steps 1 – 5*

This list applies when a hospital is at a specific Patient Flow Framework level. All the patient groups listed below will be excluded from the actions taken as part of being on that level. The patient groups below will therefore be conveyed unless specifically agreed with the hospital.

	Excluded patients groups	IC code (LAS use)
1.	Blue call (unless a redirect is in place)	IC1
2.	Children who will be treated in paediatric ED	IC2
3.	Acute specialist pathways including HASU, MTC, HAC (& #NOF where local formal pathways exist)	IC3
4.	Maternity patients >20 weeks' gestation (direct to maternity unit)	IC4
5.	HCP referral with a named receiving clinician or REACH (Whipps Cross, Royal London and Newham Hospitals only)	IC5
6.	Actively receiving specialist treatment or recently discharged from a named hospital within the last 7 days (non-surgical) or 4 weeks (post-surgery)	IC6
7.	Patients with an acute Mental Health condition that are a risk to self or others (where there is no dedicated MH ED available)	IC7

*SDEC, UTC, Fit to Sit and patients with a social care package are no longer excluded.

Escalation Framework

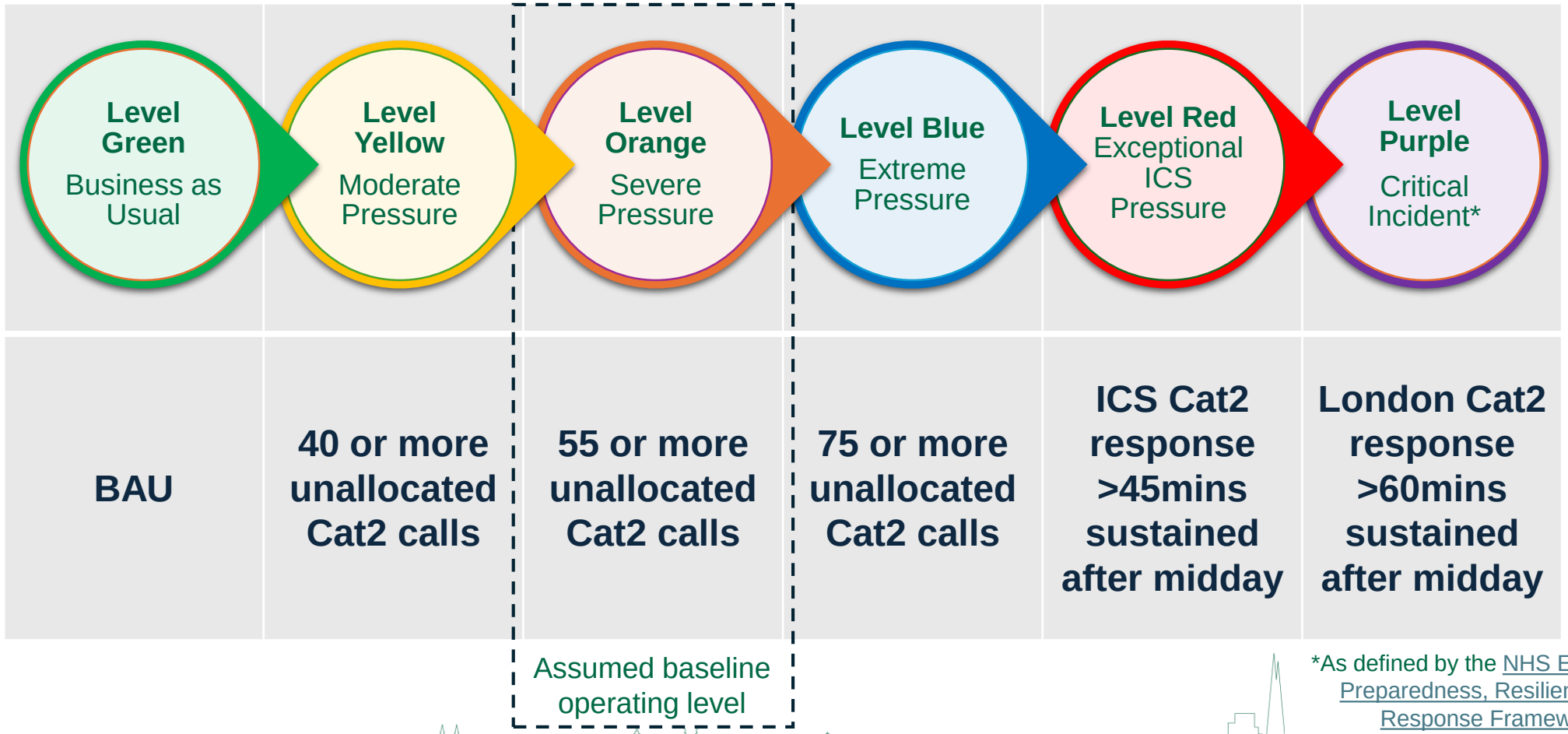
Clinical Safety Oversight and Escalation

Clinical Safety Plan (CSP)

- CSP is a dynamic plan which ensures the best response to our sickest and most seriously injured patients at times of increased pressure.
- During Winter, the escalation baseline will be CSP Orange.
- Two new levels of Red and Purple have been added. These levels will be activated in response to sustained UEC system pressure and would be a joint London response.

New CSP escalation levels – Red and Purple

In view of discussion around collective risk, we are proposing a six level Clinical Safety Plan with Red and Purple being new levels introduced to denote ICS or pan-London sustained exceptional pressure



*As defined by the NHS Emergency Preparedness, Resilience and Response Framework

Red and Purple escalation process

- System agreement is needed to move to red and purple levels, a call will be convened during the day to discuss the current pressures and agree an ICS plan
- The LAS IDM will review triggers by **12:00**, for a call to be convened by **13:00** and escalation level put in place by **14:00**
- Escalation will be in place until **midnight** unless pre-agreed triggers to de-escalate have been met
- A review meeting will be considered and planned at the initial meeting (e.g. around 16:00, before LAS evening handovers commence)

Red triggers – ICS specific	Red System Call attendance
Cat 2 performance – Greater than 45 minutes in affected ICS sustained after midday	• Chair – ICS Gold when in isolation, or NHSE London Gold when multiple ICS affected • ICS SCC representative • LAS – Exec/Gold, SMA • ICS – Gold of each affected ICS • Hospital Trusts – Gold of every ED hospital Trust in the ICS • Other providers as required by ICS e.g. community, MH
Hospital handover hours increase – Above 26 minutes average in an ICS	

Purple triggers – Pan-London	Purple System Call attendance
Cat 2 performance – Greater than 60 minutes sustained after midday, pan-London	• Chair – NHSE London Gold • ICS SCC representative • LAS – Exec/Gold, SMA • ICS – Gold of every ICS • Hospital Trusts – Gold of every ED hospital Trust • Other providers as required by ICS e.g. community, MH
Hospital handover hours increase – Above 26 minutes average pan-London	
Significant respiratory illness in the community as evidenced by increasing demand of these patient groups presenting to 999/111/ primary care, leading to disproportionately high percentage of Category 1 and 2 patients. UKHSA data would also be considered.	

Level Orange – Severe Pressure

Cat 2-5 patients who will continue to receive a 999 response	LAS actions	System support needed
• Patients where the caller is not with the patient • Age < 1 Year • High risk chest pain, epilepsy and bleeding (including blood thinners) • Patients where communication to assess them remotely is difficult • Patients with specific urgent care plans • Vulnerable fallers still on the floor • High risk mental health and overdose patients • Patients who volunteer information about Cancer Treatment or Steroid Treatment • Pregnancy > 20 weeks • All other category 3 – 5 patients will be referred to alternative health care facilities • Cat2 calls handled as per Cat2 segmentation process	• Dynamic deployment of HALOs to support LAS-led cohorting and W45 • Reduced on scene time (30 minutes) for conveyed patients • Trusted assessor to reduce conveyance • Focused clinical record for conveyed patients • Maximise use of ICS alternative care pathways	• Continued support of W45 • Accept patients with focused clinical record • Accept patients referred by clinicians who may be remote from the patient

Early clinical decisions on scene

- There will always be a proportion of patients for whom conveyance to hospital is appropriate and the right decision.
- Guidance has been refreshed to support ambulance clinicians making early decisions to convey for these patients and tailor their on-scene management
- The time on scene should be no more than 30 minutes on average
- There is good evidence that hospital transfer delays worsen outcomes in a number of conditions:

  e.g. STEMI, stroke, major trauma, etc.
- Impact for the wider system:
  - ➢ Patients conveyed without delay on scene
  - ➢ Only essential decision-making interventions will be done pre-transfer e.g. ECG, BM, pain relief.

LAS crews will obtain a focused ePCR clinical record when conveying a patient to hospital

- In contrast to see, treat and refer (non-conveyance), when conveying a patient during CSP Blue a more focused approach will be taken when completing the ePCR
- The intention is to avoid unnecessary delays where the patient needs hospital treatment and to reduce duplication of hospital assessment and investigations
- This will cover relevant critical clinical information and assessment / management
- More information may be added en route or whilst awaiting handover if required
- If a clinician considers there is critical information that requires recording for patients safety/care – this is, of course, supported
- Impact for the wider system:
  - Patients conveyed will have a focused clinical record

Handover of patients suitable for non-conveyance

- As the whole UEC system is very busy there are understandably delays, at times, to receive referrals. This results in delays on scene and avoidable conveyance.
- To reduce the amount of time crews spend on scene, ambulance clinicians will be able to refer their patient to another clinician to make the referral on their behalf. As Integrated Care Co-ordination Hubs (ICCH) develop in each ICS we would anticipate them to take this responsibility.
- In the meantime, LAS will refer the patients to a dedicated additional paramedic in the 111 CAS using an electronic referral form. The paramedic will review the information and then refer the patient onto the out of hospital pathway.
- The potential other options in the ICSs are:
  - NWL & NEL – use the REACH service in relevant parts of their geography
  - NCL – ICCH – potential go live in November
  - SWL – explore use of Consultant Connect
- Impact for the wider system:
  - ➢ Patients will be referred via the CAS paramedic rather than by the clinician on scene
  - ➢ The ePCR will be visible to the CAS paramedic and clarity will be able to be given if there are any queries
  - ➢ If a referral cannot successfully be made within 60 minutes then a clinical review will be undertaken before a further frontline ambulance is dispatched.

Level Blue – Extreme Pressure

Cat 2-5 patients who will continue to receive a 999 response	LAS actions	System support needed
• Patients where the caller is not with the patient • Patients where there is a safeguarding or safety concern • High risk mental health and overdose patients • High risk chest pain, epilepsy and bleeding (including blood thinners) • Vulnerable fallers who are still on the floor • All other Category 3 – 5 patients will be referred to alternative health care services • Cat 2 calls handled as per Cat 2 segmentation process	• W45 without exception • Reduced on scene time (30 minutes) for **all** patients • All healthcare professional or interfacility transfer Cat 3 – 5 patients agreed only with clinician to clinician conversation	• W45 without exception • Use of hospital transport or own transport for patients who do not require an emergency ambulance • SCC to manage flow requests

Level Red – Exceptional ICS Pressure

All actions below to be agreed by relevant ICS before being implemented:

Cat 2-5 patients who will continue to receive a 999 response	LAS actions	System support needed
• As per Blue, and in addition: • All Category 2 patients within ICS to be clinically validated and assessed / navigated before ambulance dispatched	• W30 enacted in affected ICS • Reduced on scene time (30 minutes) for **all** patients in affected ICS • All healthcare professional or interfacility transfer Cat 3 – 5 patients agreed only with clinician to clinician conversation	• W30 enacted in affected ICS • Providers within ICS expected to prioritise emergency care access for patient groups that LAS cannot get to, such as MH and fallers (each provider to consider relevant groups) • Use of hospital transport or own transport for patients who do not require an emergency ambulance • SCC to manage flow requests

Hospital Handover at 30 minutes

- Ambulances held at hospital are needed to respond to patients waiting in the community.
- Clinical handover of the patient should occur within 15 minutes of hospital arrival. If this has not occurred at 15 minutes contact PD46.
- Patient handover should also occur within 15 minutes. If this has not occurred at 20 minutes contact PD46 who will escalate.
- At 30 minutes leave the patient in the department, document the name/role of the staff member you informed and the time. Include a final set of observations and highlight any additional concern in the ePCR.
- Advise EOC of Immediate Handover
- Impact for the wider system:
  - Patients will be handed over at 30 minutes (note: national standard of 15 minutes)
  - LAS will continue to support cohorting to release vehicles
  - LAS will ensure trolley beds etc are collected from EDs.

Level Purple – Critical Incident

Patients who will continue to receive a 999 response	LAS actions	System support needed
• Cat 1 & 2 patients who are deemed to need an immediate response because they have a life threatening or life changing time critical condition	• Rapid release – immediate handover • All clinicians patient facing • All non-core activity cancelled • Single resource to each patient (2 resources for cardiac arrest / maternity) • Maximise self-conveyance	• Rapid release – immediate handover • Cat 3-5: face to face responses provided by other providers in the relevant ICS • SCC to manage all flow requests • Increase clinicians at front door as sicker patients will self-present • Use of hospital transport or own transport for patients who do not require an emergency ambulance