

Operations

This special bulletin contains urgent information for staff in all Trust localities.

DYNAMIC DEPLOYMENT PILOT - Q&A

Q. Why do we need dynamic deployment?

A. The short answer is to put us closer to the patient in their immediate moment of need. As an ambulance service we have historical information on who our callers are and when and where they need assistance; mapping that information over both time and geography (known as demand analysis) has enabled us to predict demand and prepare to meet it in the right time and at the right place. It is recognised internationally from the work first done in the 1980s by Jack Stout that it is accurate enough to make a significant difference to our ability to reach the patient quickly.

Q. Why do we need to harmonise dynamic deployment across the Trust?

A. The three operational areas of the Trust currently use different methods of placing and deploying vehicles. The key reason for harmonisation is to fully utilise the evidence base we have from our data to achieve a consistent approach to the science of emergency vehicle deployment.

Q. Where does the data analysis used to identify dynamic deployment activation points come from?

A. As discussed, we are "data rich". Every key stroke made by call takers during the call cycle, information from crews via their mobile data terminals and downloads from Automatic Vehicle Locating (AVL) systems are placed in the Trust's data warehouse for use as management information and to help us make decisions. This information is then processed to provide the operational intelligence to develop our deployment plans.

Q. Will all sites have full facilities?

A. Not initially. In areas where dynamic deployment has not been the norm it will take time to establish more permanent facilities, such as response posts, than currently exist. The ultimate aim of this project is to provide facilities at the right place to provide a safe, fit for purpose deployment point from which crews are available to attend patients in a timely fashion.

Q. What facilities should there be at an

activation point or response post?

A. Appendices 1 and 2 set out the criteria for the different levels of facilities.

Q. Can I refuse to go to an activation point location?

A. Yes, if you are into the last 30 minutes of a shift.

Q. Can I refuse to go to an activation point that does not have the specified facilities?

A. Only in the last 30 minutes of a shift. At all other times during the pilot scheme, deployment at dynamic activation points without the specified facilities will be limited to 45 minutes from time of arrival. Resources, having spent 45 minutes at a dynamic activation point, are entitled to request via HEOC to be moved to a response post, station/depot or alternative agreed location.

Q. What if I'm asked to go somewhere I do not consider to be safe?

A. You should initially deploy immediately. You should initially deploy immediately. However if, having carried out a personal risk assessment on arrival, you feel a specified area is not safe then you must raise the matter with HEOC and try to find a suitable alternative close to the specified site. Longer term, raise the issue with your local manager in order to find a more appropriate location.

Q. What types of vehicle will be utilised on dynamic deployment?

A. The pilot applies to all types of vehicles as indicated in Scope (section 2.1) which includes singletons and ambulances. By applying this across all our response capability the aim is to help us distribute the workload across all resources as fairly as possible.

Q. What if you don't have a lone worker policy?

A. NSC and Essex have their own individual Lone Worker policies whereas B&H do not. Therefore the B&H Single Crew Response SOG (2.4 - Version 4 July 2002) would apply.

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Q. Why are you putting performance targets above our health, safety and wellbeing?

A. While there is a science to the plan and the locations where deployment should be operated from, the introduction of dynamic deployment is being undertaken with a mind to the health, safety and wellbeing of staff. For example, in determining how long staff should be deployed at dynamic activation points, the group sought the advice of our occupational health doctor. While the advice provided from them suggested that 90 minutes would be appropriate, discussion around this issue was significant and went beyond the purely medical to include discussion around job fulfillment/enrichment and the negative effect of reduced staff interaction with each other. The time for which staff can remain on an activation point without facilities was therefore reduced, following highly credible and valuable discussion prompted by staffside which gained the support of management, resulting in the 45 minutes now contained within the pilot. We will continue to test and adjust the plan as the pilot continues. Staff safety, along with patient wellbeing, is of paramount importance to us at all times.

Q. If I have been at a standby post for as long as 45 minutes, is the standby location in the wrong place?

A. Dynamic deployment is not a 100% exact science, and the demand data that informs the deployment plan is used according to a formula which has been well tested across the world. It is only through trial and piloting that we will know if a location is wrong, or that the location is right but the times at which it is manned may need to be adjusted. The rationale for dynamic standby is, as discussed earlier, to put you in the right place to reach the patient in the right time, which is when they need us. If a demand pattern shifts, relocation of a point should occur to reflect this.

Q. How do we ensure fairness of allocation to activation points or calls?

A. It is very important to ensure fairness of allocation to activation points across the entire shift workforce. We acknowledge that there may be times of high demand when a crew will return to an activation point more than once. However, this will be actively managed in HEOC to ensure equity for all in the longer term and monitored by staffside and management representatives

Q. What is a temporary holding area (THA)?

A. An area or site for use in exceptional circumstances, examples of which are identified in section 10.1 of the document. A good example

of a THA was during the evacuation of Felixstowe in the summer after a 1000lb WWII bomb was discovered. Crews mustered at a THA until called forward to undertake evacuation tasks inside the cordoned off area of the town.

Q. Why is it called a temporary holding area?

A. Simply because the group couldn't think of anything better! If you have any suggestions, the dynamic deployment group would welcome them.

Q. For how long will the pilot last?

A. Until the end of March 2009.

Q. As the document refers to "all clinical staff" does this include managers?

A. Yes. The Trust has frequently deployed managers to standby during periods of high operational pressure.

Q. Is this the only chance we will get to give our comments?

A. No, you will be able to submit comments throughout the pilot, which will be fine-tuned at monthly meetings or "live" intervals if there is something which needs changing immediately. Staff are encouraged to feed in constructive comments and suggestions to help shape the policy on an ongoing basis until the end of March 2009.

Q. What's the difference between a response post and a dynamic activation point?

A. They differ as regards their location, the expected level of facilities provision and the length of time that a resource can be expected to remain in on site. Definitions of both can be found outlined in sections 7 and 9, and Appendices 1 and 2 will outline the expected facilities arrangements.

Q. How will the progress of the pilot be monitored?

A. There will be monthly meetings between management, HR and staff side, and we will utilise the information generated via the "Lightfoot" system in Essex and soon to be in NSC. Also, the trial will be monitored on an ongoing "live" basis.

Q. Has the environmental impact regarding fuel, emissions, noise, engines running etc been considered?

A. This has been discussed at length and, with the imperative to hit government targets, must currently be considered secondary to patient safety.