Please find below a list of questions which GMB@EMAS asked the Chief Executive Mr Phil Milligan to respond to and to provide evidence to support their case for the 'Being the Best' changes. As you will see, apart from re-quoting the brochure he hasn't really offered any new evidence that would sway the GMB@EMAS to support what we believe to be a flawed plan.

What the committee must bear in mind is, when this plan was originally unveiled to the trade unions back in July, the original plan was centred around 33 'hubs'.

Mr Milligan then broke the news on local television on the 17th July 2012 that EMAS NHS Trust was looking at a change and that the plan centred around 13 'hubs'. This, we believe, was where the deception began.

The numbers below do not run in sequence as I have removed those questions that referred to areas other than Leicestershire.

Black – Original question put to Chief Executive
Green – Phil Milligan's Reply to our questions.
Red – GMB@EMAS Response to the reply.

1. **Has EMAS consulted with other services that have gone through a similar process of change to a hub and spoke model and if so what was their feedback regarding how successful this model is in both rural and densely populated areas?**

EMAS has spoken to both South East Coast Ambulance Service and West Midlands Ambulance Service about their estate changes. There have also been visits, informal discussions held with Canada who run a similar model. Both Trusts remain two of the top performing Trust in the country for both A8 and A19 response with their time to treat indicators remaining strong.

Our consultation programme is aimed at ensuring that we hear the views of the public, our staff and staff side before the final plan is presented to the Board. This approach we feel follows our values as an organisation that values the views of others.

You have not provided us with any detailed written 'feedback'. Please provide us with details of the structures and locations of the hubs and spoke for all three organisations. Also, when did EMAS visit Canada and who went?

2. **You claim in your documents that the estates review will provide "better support for staff", you state that staff will be able to speak to a line manager at the beginning or end of their shift, this would indicate 24/7 management cover at the hubs. Will this mean that the team leader will be ring-fenced from responding to calls and solely office based?**

Currently Paramedic Team Leaders, Operational Support Managers, and divisional management teams i.e. Service Delivery Managers, Clinical Quality Managers and Assistant Directors of Operations and Human Resources representation, are based across the patch. The introduction of 13 hubs will mean more management and support presence in the one location, resulting in more managerial support being available for longer periods of time at the Hub. The proposed management changes have been designed with staff support at the forefront of the proposals. It is envisaged that the Team Leaders will be available around the clock to support staff during the normal course of their duties a hub with a minimum 120 staff will have 6 team leaders based there, 6 team leaders is sufficient for 24/7 cover. In addition there will be a locality manager and a locality clinical quality manager, again providing the resource for team support.

Team Leaders (not LCQMs or Locality Managers) will have protected management time but will also be expected to respond. These responses will usually be with a member of their team, allowing further 1:1 discussion and supervision. The current practice of team leaders usually responding as 'solo' will reduce. However, there will remain other support requirements, in response, e.g. incident site supervision.

EMAS have launched a supportive management programme which will ensure that the post holders have the necessary skills to support staff.

That is a long winded way of saying no. How much 'protected management time' will TLs have and explain 'protected'.

3. **At the EMAS AGM the Chief claimed that "staff will no longer have to check oil, washer bottles or equipment" and that "staff will be able to turn out straight away with a clean, well stocked vehicle", has EMAS confirmed with the HPC and Police to see if this is a suitable practice and therefore no responsibility lies with the crew for the level of equipment on board or road worthiness? If so can we see copies of this correspondence?**

We have received advice from other ambulance organisations that our proposals are sound, we will be seeking formal written advice from the police on these matters. It is proposed – and we're asking for views via our consultation to help us develop and shape these proposals -that when crews arrive at the Hub, the Make Ready team go through the check list with the clinician to confirm what has been done and to complete the final checks for which the clinicians will still have responsibility for i.e. ensuring the tyres and lights work.

Reducing the amount of checks the clinician has to complete will vastly improve the time it takes to get crews out on the road to respond to calls. This means that vehicles will leave the hub fully stocked and checked, as opposed to what happens currently when crews starting their shift have to make the decision whether to respond to a 999 call before they complete their check, or to complete the checks which results in a delayed ambulance response and therefore delay to treatment and patient care.

As part of this consultation process we will be speaking with all of the relevant organisations to ensure that our final proposals meet the relevant statutory requirements.

Have you spoken to the police about this or HPC? If so, please provide the correspondence.

4. **On many occasions the Chief has stated that "it takes around 30 minutes at the start of each shift for the highly trained clinicians to check the vehicle", can we see evidence of this statement?**

Since joining EMAS in December 2011, the Chief Executive has made it his business to understand what life is like for crews on the frontline. This includes going out on announced and unannounced observation shifts, asking direct questions of staff via his weekly email bulletin and receiving responses, meeting with staff, staff side and talking to managers about the issues raised.

The statement of '30 minutes' is an average, and comes from the feedback received direct by the Chief Executive, and from his experiences when arriving at station before shift handover.

So there is no actual evidence, just the Chiefs opinion.

5. **If the claim that the Trust will be gaining 30 minutes of operational time back is true then has this time been added to the make ready time as they will now be the ones checking and restocking the vehicles. If so where is the evidence for this? Will there be an increase in make ready staff to reflect the increase in workload?**

As above, the term '30 minutes' is an average based on feedback given during conversations between frontline staff and EMAS Chief Executive. We are clear that staff often state they have to decide whether to respond to a 999 call before they complete their check, or to complete the checks which results in a delayed ambulance response and therefore delay to treatment and patient care. It is envisaged that recruitment to the Make Ready teams will be necessary; however, we can only be clear on the level of staffing needed after we have considered all the feedback received during this consultation period i.e. in parts it will depend on the

final number of Hubs based across the East Midlands, and the role that we require Make Ready to take.

How many make ready teams and how many per team? Based on your current plan where are the costings for this?

6. At the AGM and in response to a question posed about a potential increase in mileage by trust vehicles as they will be based in 13 hubs rather than 66, the Chief claimed that "they will actually do less mileage", what is the evidence for this statement?

Our Community Ambulance Posts and standbys will be strategically placed. This is supported by lessons learnt from other ambulance services who have adopted the same approach.

Vehicles being fully stocked before they start the shift will result in less journeys back to station to restock during shift – in most cases there should be no need to return to the Hub during a shift in order to restock.

It is intended that Hubs will have fuel bunkers on site thereby reducing the amount of travel taken to refuel.

We are exploring how vehicles can be serviced and maintained at the Hubs and so will not need to travel to Alfreton or Gorse from all locations, thereby reducing the amount of current travel taken.

Better management of our standby points and the introduction of more facilitated Community Ambulance Posts will reduce the amount of travel crews take when they need a comfort break from a standby that has no facilities. whether to respond to a 999 call before they complete their check, or to complete the checks which results in a delayed ambulance response and therefore delay to treatment and patient care.

Facilitated Community Ambulance Posts will mean crews will not need to travel back to base to take their meal break.

Please show us the evidence as your claims are challengeable.

8. At Retford Town Hall during the public consultation meeting the Chief claimed that "Land sales will raise 29 million and the cost of these hubs and CAPs will be 29 million" where is the evidence for this statement?

This was published in the board papers in July and can be found on the trust website under the 'About Us' tab.

We want this breaking down station by station and also the cost of refurbishment by station too.

10. **Whilst being interviewed by Andy Whittaker on BBC Radio Nottinghamshire on 17th September the Chief stated "you will get a better response for patients, better service for staff and faster response to patients", how has this been calculated and where is the evidence?**

The report presented to the Board presents the evidence for this.

Better response for patients: Our proposals include the introduction of more Emergency Care Practitioners meaning more patients can be seen and treated at home and saved from an unnecessary journey into a busy hospital department, or have their care passed to a more appropriate healthcare provider.

Better service for staff: Staff will be based at Hubs which include local services like fleet and make ready to provide support at the time. They will be supported by a 24/7 management presence in the Hubs, communication will be improved (eg team leaders will be able to better schedule and advertise team briefings and meetings, knowing they will be on base more often) and the introduction of Community Ambulance Posts with facilities will mean better working environments and places for staff to rest and take their meal break.

Faster response to patients: Process Evolutions modelling demonstrates an improvement in response times across A8, A19 and G codes. The introduction of Urgent Care crews will mean that our paramedics and ambulances with life-saving equipment on board are kept available to respond to the real life-threatening emergencies. Many of these issues have been raised as concerns by staff in staff survey results.

No evidence provided.

11. **In the briefing sent out on 14.9.12 via email for Being the Best, it claims that the new proposals will "allow clinicians to respond faster to patients and means they can take more advantage of the treatment, care and technological advances available", Can this statement be explained and evidence provided to verify this statement.**

Process Evolution modelling demonstrates a quicker response as previously outlined. Put simply, by responding quicker to patients, they can expect to receive the full benefits of the treatment and care we can provide by getting to the patient faster i.e. reaching patients who are suffering a cardiac arrest or stroke quickly greatly improves their chance of survival and rehabilitation, and in addition we can utilise the technological advances better by getting patients to the specialist centres within the required time frame to allow them that opportunity. Our management proposals for clinical managers is intended to allow exploration of where we can extend practice min the community, what new technologies are available that we can use locally and how can we support staff training.

No evidence provided.

12. In the briefing sent out on 14.9.12 via email for Being the Best it states "use of standby points and CAP's will increase", how will this be facilitated?

In the same way as we dispatch to standby i.e. via our Emergency Operations Centre. However, standby is not used efficiently enough at this time – particularly because the majority of standby points are not facilitated and so the introduction of facilitated Community Ambulance Posts will allow us to make better use of the strategic points.

Standby points are used predominantly by cars as the Double Crewed Ambulances are flat out. Therefore the question remains unanswered.

13. Currently DCA's rarely get to standby points due to operational demand, how does the Trust intend to cover an increased number of points with the same demand?

The outcomes of the management restructure and new operational model aims to increase the number of resources that are currently put out on a daily basis. This will support covering more points that are currently achieved. In addition, we know that the Community Ambulance Posts will be used more frequently because they will be facilitated areas as opposed to a layby or car park where crews cannot make a drink or use the toilet.

What do you mean by 'resources'?

14. Will these vehicles be protected from receiving jobs until they reach their standby area?

We will always send the closest available resource to an emergency – as we do now when an ambulance is on route to its station having taken a patient to hospital. The crews which work within a designated part of the county will continue to do so and by ensuring sufficient resources are available at all times there will be no need for current practice to change. Evidence tells us that it is more effective returning crews to their own area after an incident.

The answer is no then. Please show us the 'evidence' you refer to.

15. Has additional travelling time from Hubs to CAPs been calculated in ambulance down time, if so where is the evidence for this?

Ambulances will be available to respond from when they come on duty, so there will be minimal down time. The Rota Review is looking at our shift pattern so we can be sure that we have cover available in each area, and to be able to manage shift change over on a staggered basis.

The answer is no then.

16. Have the trust got clarification from CQC and/or HSE with regards to carrying food on ambulance vehicles? If so please provide this correspondence.

We are looking at how food can be carried on a vehicle so staff can have their meal break at a Community Ambulance Posts and we will be / are working with staff in the working groups (advertised in the Chief Executive bulletin, asking staff to be actively involved) to identify a solution for food to be carried safely. We do not require CQC nor HSE approval, the Trusts policies, procedures and health and safety structures are sufficient to ensure that the final proposals are safe. Staff Side have health and safety representatives and they will be involved in the detailed discussions on how to take this issue forwards.

You have not provided the correspondence. Does it exist?

17. Have the service done a risk assessment on staff spending longer periods sat in vehicles? If so please provide this evidence.

The introduction of Community Ambulance Posts will mean that staff will not have to spend a significant time in the vehicle because they will have more facilitated rest areas.

No risk assessment then?

18. If vehicles need restocking, cleaning or the member of staff needs to change uniform during a shift then where will this be done? Has this mileage been included in any calculations and if so where is the evidence for this?

The vehicles shouldn't need restocking for the majority of shifts because the Make Ready teams will have ensured they are fully stocked before going out on the road.

Basic cleaning materials will still be available on board vehicles and at Community Ambulance Posts, and so the only need to return to a Hub will be for a deep clean, or as you suggest a uniform change. As part of the consultation process we want to take in to consideration all factors which affect staff and collectively identify the most effective way forward with our proposals.

So, the extra mileage hasn't been taken into account.

19. How are these CAPs going to be maintained and cleaned? If this incurs costs have these been included in the Trusts calculations and where is the evidence for this?

As part of the future business case we will have to identify where additional cleaning/maintenance support would be required over our existing staff base. If the facilities are shared with other organisations we would look to develop an agreement which is mutually acceptable.

This issue has not been taken into account.

20. Has the Trust considered that response times may increase as "the computer" does not take into consideration road conditions, volume of traffic, weather conditions and staff fatigue from extended driving times, if so then please provide the evidence?

There is currently no evidence that suggest staff fatigue will increase under the new proposal, indeed included in the Rota Review is the suggestion that we have a mix of 8, 10 and 12 hour shifts. Our Management Structure Review is about having a more efficient service allowing us to better manage our response to emergency calls. The Estates Strategy includes having fleet and make ready services available at all hubs, reducing the amount of Vehicles Off Road – thereby having more vehicles available to respond to calls. The impact of the other factors outlined can materialise under the current estate model, and so they are issues we are fully aware of.

No evidence presented.

21. In the FAQ's the Trust states that the average increase in travelling to work will be 3 minutes, show us the evidence for this calculation broken down into stations.

When conducting the hub and TDP optimisation process the effects upon travel times to work of moving operational staff was analysed. Based upon their existing station locations operational staff have, on average, a travel time to work of 17.4 minutes. If PTLs and the staff they are responsible for are always co-located then operational staff would then have, on average, a travel time to work of 21.5 minutes, this is approximately an average increase of 4 minutes.

This is an average figure and we recognise is not wholly representative because whilst the analysis showed some staff may have to travel shorter distances, others will have the journey time increased by much more. We are very aware of the potential impact on some staff and are using the consultation period to work through
how to minimise this.

No evidence presented.

22. In many documents the Trust claims that the new proposals will add operational hours into the system, please provide the evidence to support this.

Staff will be able to respond immediately from the start of their shifts as there will be a fully stocked, checked available vehicle for them. Currently they may have to wait for a vehicle and would need to spend time checking their vehicle prior to commencing their shift. Having fleet and make ready at hubs will result in less vehicles being 'off road'. Having more facilitated rest points i.e. the Community Ambulance Posts, will mean less time travelling back to station for a meal or comfort break. Alongside the estates and rota changes the management proposals will see approximately 46 fewer managerial roles. Many of those affected by change are trained clinicians and as such will be supported in a return to operational duties.

Additional hours from the following areas will help us to provide cover in excess of that presently available.

- **Time spent at beginning of shift checking, cleaning and stocking vehicles**
- **Time spent VOR**
- **Time spent travelling to base for meal breaks**
- **Time spent re-fuelling**

No evidence.

23. It is stated the FAQ's that "in depth analysis has taken place", please provide this.

The work undertaken by Process Evolution has undertaken a series of in depth analytical processes:

To conduct the optimisation analysis and to assess the impact changes made would have on EMAS performance two pieces of software developed by Process Evolution were used:

Facility Location Planner: This software was used to find the optimal locations for tactical deployment points across all five divisions of EMAS and to allocate these points into an optimised number of despatch groups with associated hub locations

Ambulance Response Profiler: This software was used to assess the impact upon EMAS performance of any changes made to the Estates Strategy

Facility Location Planner

When conducting location optimisation the number of potential combinations those locations may take increases exponentially as the number of locations required increases. For example, to decide where to put one location out of 100 possible options requires 100 tests to find the 'optimal' solution. To find the optimal solution

of two locations requires 100*99/2 = 4950 tests and there are 79,776,075,565,900,400,000,000 ways of selecting 24 locations out of 100 possible options – clearly to test every combination would not be practical.

Facility Location Planner (FLP) is a tool that uses heuristic algorithms to intelligently refine and improve solutions, removing the need to test every single potential combination of locations in an optimisation analysis. Its role within the work is twofold:

Obtain the optimal number of and locations for tactical deployment points across the EMAS Trust area

Allocate these tactical deployment points into an optimised number of despatch groups with associated hub locations, so that each group contains tactical deployment points within a desired travel time of their associated hub

Incident Data

Raw incident and deployment data has been provided by EMAS for the period 1st April 2011-31st March 2012. This was used to generate the following key inputs:

Overall annual volumes for the 2011/12 financial year

How these incidents split into difference incident categories

How these incidents split across the geography

When optimising locations the geography covered must be split into areas that show the location and concentration of incidents across the trust.

Consequently the locations of each incident within the year were allocated, based upon its postcode, into its relevant Lower Super Output Area (LSOA). A LSOA is a subset of a Super Output Area, which is defined as "a geographical area designed for the collection and publication of small area statistics". It is used on the Neighbourhood Statistics website, and has a wider application throughout national statistics.

Process Data

Travel Times: The time taken to travel from each LSOA to all of the other LSOAs within the EMAS Trust boundary was generated using Microsoft MapPoint 2011. An allowance was made for the fact that emergency response vehicles will typically be able to travel at faster speeds than normal vehicle.

Ambulance Response Profiler

Ambulance Response Profiler (ARP) is a computer simulation model used to accurately predict the effect on performance against response standards of various 'what-if' scenarios. Its role within this work was also two-fold:

Predict the impact on performance of the optimised tactical deployment points and hub locations

Predict the impact on performance of the changes made to the optimised solution to account for practical considerations proposed by EMAS operational staff

<u>Key data inputs, data sources and assumptions</u>
Clearly any model such as ARP is reliant on good quality input data to ensure that the outputs of the model are an accurate reflection of reality.

Incident and Deployment Data

Incident profiles

- **Overall annual volumes for the 2011/12 financial year**
- **How these incidents split across incident categories, geography (post code sectors), weeks of the year (seasonality) and hours of the week (weekly demand profile)**

Allocation times, Mobilisation times and At Scene times

- **These are split by both incident category and vehicle type to provide the most accurate profile possible**
- **Distributions of data are used (as opposed to just averages) to ensure that the impact of both shorter than average and longer than average times is modelled**

Conveyance rates to hospital

- **Split by incident category and whether the first arriving vehicle was an ambulance or car**

Hospitals attended and Handover times

This answer is clearly cut and pasted from a report from Process Evolution, who are selling their services to EMAS. You have shown us nothing.

24. It is stated in the FAQ's that "vehicles will be stocked at the start of the shift so there will be no need to return to a hub", how will the trust ensure this?

Crews will start their shift with a fully stocked vehicle – prepared by Make Ready as already highlighted in this document. The aim will be to have a store of consumables at our receiving hospitals to allow staff to replenish any used stock. Together, this will vastly reduce the need for crews to return to the hubs.

Have EMAS spoken to the hospitals about this yet?

25. Will the hubs be the only resource for fuel? If so then this will mean a return to base at least once a shift for some vehicles, have these miles been added into your calculations?

No, crews will also be able to get fuel from petrol stations as they currently do. But vehicles will be fuelled at the beginning of the shift and therefore the number of 'in shift' refuelling episodes will be reduced.

That would depend on where the vehicle goes during the course of its shift, not where it was first fuelled.

26. In the FAQ's you state that "the modelling takes in to account all travelling time", please provide this evidence.

Data was provided by EMAS to Process Evolution with the home postcodes of operational staff up to and including PTL level. The map below shows the concentration of those staff by postcode sector.

The vast majority of the staff concerned live within the EMAS trust boundary, with a small number living outside that area.
It is noted that some of the postcodes that were outside the EMAS boundary may be anomalies, such as someone that may have recently started working for EMAS but has yet to sell their home or someone that lives further away but stays closer to work at an alternative property when required; however it was the most accurate up to date information available.

This information was used to calculate the average increases in travel time for staff which are shown in question 21.

When averages are used it can be skewed one way or another by high concentration of people in one area or another. Therefore, we would like this calculation by station.

27. In the FAQ's you state that you will try to introduce a system where crews will be deployed to nominated areas that they are familiar with, how will this be put into practice?

The same way current crews are sent to standby points in their local area by the Emergency Operations Centre.

Crews are very rarely sent to standby points. As you said previously, the crews will not be ring-fenced and returned to their area.

28. You state in FAQ's that we have 400 vehicles and only use 252 at peak, surly if you plan to have on ambulance out being used and one in the garage being fully stocked, fully cleaned and serviced you will need 504? Please give evidence that you have calculated that we have enough vehicles for the proposed plans.

The tables below are a result of the analysis undertaken by Process Evolution in relation to the maximum number of vehicles required without the relief capacity. We are confident that there are sufficient vehicles available within the fleet to meet the relief requirement and will be supported by the future fleet procurement plans where we envisage that we will have a younger fleet requiring less downtime.

Staff per vehicle	Staff	Derby Notts	Leics/Northants	Lincs	Total
1	FRV	112	105	90	307
2	DCA	569	471	406	1446
1	ECP	42	40	20	103
2	Urgent	69	41	6	115
	Total	792	657	522	1971

Max Vehicles

	Derby Notts	Lics/Northants	LIncs	Total
FRV	24	22	19	65
DCA	62	49	42	153
ECP	8	8	5	21
Urgent	11	7	2	20
Total	105	86	68	259

These two tables resemble the 6.2.3 and 6.2.4 tables in Paper 2, but there are some differences. Why? Also, is the 252 or 259 figure (depending on which table) the number of vehicles you intend to have in the fleet or is this the maximum in use at any one time?

29. The Chief quoted on the radio that 10,000 more patients will get a response with the new proposals, show us the evidence to verify this statement Each 1% of performance improvement benefits around 10,000 patients.

No answer provided.

Therefore, is the figure of 10,000 is dependant on this plan achieving a 1% improvement.

30. It is stated in many documents that it would take £13 million to bring the current estate up to standard, how was this calculated and please show the evidence.

These costs are part of normal estates activity under the heading of six facet appraisals; these are undertaken regularly by professional consultants who assess the estate against a predetermined set of NHS criterion.

No evidence presented.

31. How much has it cost the Trust to commission Process Evolution for this project?

The Trust believes evidence based decision making is a key ingredient to ensuring sound improvement to our services. We sparingly use external resource where we do not have in-house capability. We have spent £42k with Process Evolution for their expert assistance with the estates reconfiguration to date.

Is there any further costs expected and if so how much?

32. What is the overall cost to EMAS of this project to date?

The overall estates project has so far had two phases, the initial work up to the July Board where costs were incurred in modelling estate options and development costs. The total for this element (including Process Evolution as above) is approximately £65k. The second phase is still underway and it is currently anticipated that costs will remain within the amount authorised by the July Board – i.e. approximately £180k for the period up to January 2013.

Could you provide a breakdown of these costs.

33. Do you know how much Process Evolution's Independent Review has cost and if so how much?

The Independent Review is an entirely separate exercise to the Estates review and is still in progress.