Welsh Government, Health Boards and Welsh Ambulance Service Trust

NATIONAL EMERGENCY PRESSURES ESCALATION AND DE-ESCALATION ACTION PLAN

October 2013 (v1.2)

INTRODUCTION

Escalation planning is about WAST working in partnership with the rest of NHS Wales to do things differently in order to respond to patients effectrively when reacting to demand pressures and unforeseen circumstances.

De-escalation is done on the same basis.

There are different impacts on different groups of staff at different levels of escalation. For front line operational staff the impact for staff at levels 1 and 2 are minimal. At higher levels of escalation training, abstractions, shift swaps, overtime and other leave may be reviewed.

LEVELS OF ESCALATION:

Table 1 below defines the main four escalation status levels for Health Boards and WAST. These levels and the triggers which support them will be used to determine the appropriate response to escalating and de-escalating emergency pressures and the actions necessary to protect core services, in order to supply the best possible level of service with the resources available.

Table 1: Escalation status levels

Level 1 **Level 2** **Level 3**	**Steady State** **Moderate Pressure** **Severe Pressure**	Ensure all standard operating processes are functioning as efficiently as possible in order to maintain flow Respond quickly to manage and resolve emerging pressures that have the potential to inhibit flow Initiate contingencies Escalate when applicable Prioritise available capacity in order to meet immediate pressures Put contingencies into action to bring pressures back within organisational control De-escalate when applicable
Level 4	**Extreme Pressure**	Ensure all contingencies are fully operational to recover the situation Executive command and control of the situation De-escalate when applicable

Table 2 below defines the additional two escalation status levels that are relevant only to WAST. They are based on the Resource Escalatory Action Policy (REAP) levels recognised by all UK ambulance services.

Table 2: REAP escalation status levels (WAST)

Level 5	**Critical (Major Incident or Business Continuity Incident)**	Escalate when applicable Take immediate action to limit risk and prioritise resources Implement business continuity plans or major incident plan De-escalate when applicable
Level 6	**Potential Service Failure (Enduring or sustained business continuity incident or pandemic)**	Prioritise risk mitigation Implement business continuity plans or major incident plans De-escalate when applicable

ESCALATION PLAN – LEVEL 1 – STEADY STATE	
TRIGGERS	**ACTIONS**
HEALTH BOARD -4 CORE TRIGGERS APPLICABLE: Emergency admissions are within predicted levels and match available capacity Emergency Access performance 95% being maintained Available resus and trolley capacity in A&E Ambulance patients – transfer of care within 15 minutes Beds available in assessment units Predicted and known capacity to accommodate emergency and elective admissions (including community beds) Available CCU & ITU capacity No additional beds opened Elective lists proceeding as scheduled No assistance being provided to other sites/health boards No known external factors to impact upon capacity **Consider 24 and 48 hour weather forecasts (hot and cold)**	**HEALTH BOARD:** Bed meetings must be held in line with Health Board procedures Daily telephone call between WAST and A&E to communicate any potential issues that may arise Normal Health Board communications apply Any potential shortfalls in capacity to be highlighted to the operational and bed managers as a matter of urgency Identification of potential suitable outliers Ward managers to highlight any delays for packages of care/LA funding Ensure that on the day requests for ambulance transport are booked before 12.00 noon to avoid delayed discharges and transfers Ring-fenced capacity identified Bed managers/Escalation leads to physically check the hospital bed occupancy by visiting all wards and determine how many patients have not been reviewed by a senior doctor so far today. Ensure that all patients are scheduled to receive a medical review as soon as possible Expedite discharges through links with ward managers, pharmacy, social services, WAST and community teams. When booking ambulance transport ensure mobility requested is accurate in order to prevent delays Identify elective admissions for next 24 hrs and ensure they are clinically prioritised to protect as much elective activity as possible.
WAST Triggers: **Clinical and severe weather triggers in blue bold are weighted as 2** **All National performance indicators exceeded on a daily basis and MTD performance for Red 8 minute performance exceeds 65%** **Handover not exceeding 15 minutes at any site** **Green 3 calls are being triaged by nurse within 10 minutes** **There is no Clinical Risk in the community impacting on WAST's ability to respond** No significant events are planned in next 24 hours Demand is at expected levels There are no foreseeable adverse weather forecasts Staffing >95% of predicted levels required	
WAST Actions: **Clinical Contact Centre (CCC) Actions:**	
Green 3 calls transferred for nurse triage as per CRM	Duty Control Manager
Participation in daily routine bronze teleconferences	Locality Managers, Duty Control Managers, Resource Team
Clinicians to ensure utilisation of alternative clinical pathways	Duty Control Manager, Clinical Desk staff, Consultant Paramedic
Monitor and manage mobilisation times	Duty Control Manager, Allocators
Monitor and manage job cycle times	Duty Control Manager, Allocators
Monitor and manage compliance with deployment plan	Duty Control Manager, Allocators
Ensure Clinical Contact Centre occurrence log is updated	Duty Control Manager
Daily missed Red report to be completed and reviewed	Duty Control Manager, Utilisation Managers
Ensure handover to clear targets met	Duty Control Manager, Locality Managers, Utilisation Managers
Ensure all crews showing unavailable are challenged appropriately *(add NPR*	Duty Control Manager, Locality Managers, Utilisation Managers

bit from Kate) When Trust is de-escalating to level 1 ensure there is a group call broadcast to all crews	Allocators
Operational Actions: Refer patients as required to alternative pathways Ensure compliance with absence policy Monitor and manage hours provided Monitor and manage availability of fleet Ensure maximum cover of RRVs and EAs to meet demand Ensure appropriate use of Datix and SAI processes to capture and report risks/events through all levels of escalation	 Clinical staff, CTLs, Clinical desk, Locality Managers Line Managers Head of Resourcing, Resource Teams, Heads of Service Head of Resourcing, Fleet Managers, Locality Managers Head of Resourcing, Resource Teams, Heads of Service Line Managers
COMMUNICATIONS: Health Board: On-Call Managers; Operational Managers; Senior A&E Nurses; Bed Managers; Ward Managers; Clinical take teams; OOHs site managers; Primary Care locality teams; OOHs; social services. **WAST:** Duty Manager; Senior Nurse Adviser; Ambulance Liaison Officers; PCS Customer Services Manager; Locality Managers; Heads of Service ; Staff side; HR; Training; On call team; Communications team; Executive Team; Resource Team; CCC management team	

<table>
<tr><th colspan="2">ESCALATION PLAN – LEVEL 2 – AMBER LOW: MODERATE PRESSURE</th></tr>
<tr><th>TRIGGERS</th><th>ACTIONS – IN ADDITION TO LEVEL 1, THE FOLLOWING ARE REQUIRED:</th></tr>
<tr><td>HEALTH BOARD -4 CORE TRIGGERS APPLICABLE: □ Emergency admissions are likely to exceed predicted levels and available capacity □ >4 hour breaches have occurred (excluding clinical exceptions) □ Ambulance patients – transfer of care >15 minutes but less than 30 minutes □ Patients waiting more than 1hour for first contact with assessing clinician (majors & minors) □ Ability to provide resuscitation capacity □ No acute beds available within the next 30 minutes □ CCU & ITU delayed transfers of care identified □ Patients being admitted or transferred to an outlying speciality □ Unplanned bed closures ie infection outbreak □ Routine electives under review □ Midday status remains at Yellow</td><td>HEALTH BOARD: □ WAST Duty Officer and Site Operational Manager to discuss issues □ Additional transport to be provided if available. □ Review elective admissions and prioritise potential cancellations □ Review opportunity of accessing additional capacity across the health board □ Pre-emptive transfers to wards where there are confirmed discharges □ Consider option to divert to another hospital within the health board □ Risk assess infection areas outside of normal operating arrangements □ Ensure bed capacity has been accurately reviewed □ Ensure that every patient has received a medical review by a senior doctor □ Communications to primary care and GPs through locality management team
□ DE-ESCALATE WHEN APPLICABLE</td></tr>
<tr><td colspan="2">WAST Triggers:
Clinical and severe weather triggers in blue bold are weighted as 2

Red performance falls below 65% month to date or for three consecutive days
19 minute backup standard falls below 95% month to date
Ambulance handover delays are reaching 30 minutes in any given hospital
Calls being answered <6 seconds < 90%
20% of Green 3 calls waiting continually in excess of 10 minutes standard for nurse telephone assessment
Hospital diverts are in place within LHB areas
CCC staffing is <95%
NHSD staffing < 95% of planned
Significant event expected to impact on demand is planned in next 48 hours
Severe weather forecast within next 7 days
Activity is > 5% above forecast
Staffing <95% of UH Requirement</td></tr>
<tr><td>WAST CCC Actions:
Maximise use of Helimed for transfers or 999 calls
Alert CFR and co responder schemes for support
Match allocator knowledge and capacity to desks with highest demand
Review clinical desk staffing
Clinical desk and NHSDW nurse to transfer suitable Green 1 calls for nurse telephone assessment (allocator must continue to dispatch available resources to Green 1 calls until nurse confirms alternative disposition)
Alert GPs to potential delays in response to CARD 35 (1-4 hrs) requests
Offer overtime for any vacant shifts
North and C&W CCC consider implementation of remote stack monitoring</td><td>
Duty Control Manager
CFR Managers
Duty Control Manager
Consultant Paramedic, Resource Team, Duty Control Manager
Senior Nurse Advisor, Duty Control Manager, Consultant Paramedic

Call takers, Duty Control Manager
Resource Teams, Heads of Service
Clinical desk staff, Consultant Paramedic, Duty Control Manager, Head of CCC, Senior Nurse Advisor, Medical Director</td></tr>
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Operational Actions:	
Contact local EDs to discuss handover plans for next 24 hours	Locality Managers
Robust management of all vehicles reporting unavailable	Allocators, Duty Control Managers
Ensure vehicle availability for all crews for next two shifts	Head of Resourcing, Fleet Managers
Contact and pair up all single staff pre-shift	Head of Resourcing, Resource Team, Locality Managers
Consider the cancellation of all external meetings	Heads of Service, Executive Team, Directorate Management Teams
Review availability of all response capable managers	Directorate Management Teams, Resource Teams, Heads of Service, Staff side
Any short notice leave must be approved by HoS /Gold On Call	Heads of Service, Gold on call
Review non essential training and consider rescheduling	Heads of Service, Training Team, Resource Teams
Review abstractions and recall non essential	Heads of service, Head of Resourcing, Resource Teams
Contact St. John for additional support for patient transport or high dependency crews	Head of Resourcing, Resource Teams
Offer overtime for any vacant shifts in line with forecast demand	Head of Resourcing, Resource Teams

COMMUNICATIONS:
Health Board: On-Call Managers; Operational Managers; Senior A&E Nurses; Bed Managers; Ward Managers; Clinical take teams; OOHs site managers; Primary Care locality teams; OOHs; social services.
WAST: Duty Manager; Senior Nurse Adviser; Ambulance Liaison Officers; PCS Customer Services Manager; Locality Managers; Heads of Service ; Staff side; HR; Training; On call team; Communications team; Executive Team; Resource Team; CCC management team

ESCALATION PLAN – LEVEL 3 – AMBER HIGH: SEVERE PRESSURE	
TRIGGERS	**ACTIONS – IN ADDITION TO LEVELS 1 AND 2 THE FOLLOWING ARE REQUIRED**
HEALTH BOARD -4 CORE TRIGGERS APPLICABLE: Emergency admissions are exceeding predicted levels and available capacity >8hour breaches have occurred Unable to provide resuscitation facility Ambulance patients – transfers of care > 30 minutes but less than 60 minutes Patients waiting more than 2 hours for first contact with assessing clinician (majors & minors) Limited ability to create additional CCU and ITU capacity (refer to Critical Care Escalation protocol) Discharges and transfers less than predicted and will impact significantly on capacity All available staffed adult bed capacity in use, including ring fenced beds Planned commissioned additional capacity in use Routine electives cancelled Divert within health board in place	**HEALTH BOARD:** Executive Lead to be informed of situation Additional capacity accessed, including ring fenced beds and an ongoing staffing plan in place Consider divert to another health board Request WAST officer to mobilise to hospital site Emergency planning meeting convened (to include Executive Lead and other key staff as determined locally). Verify the issues and immediate requirements then agree a series of extraordinary actions to recover the situation. De-escalation criteria must be agreed and used as a measure of recovery Executive lead to contact Executive leads at neighbouring health boards to discuss and agree support, including de-escalation criteria Communications Team to be kept informed to ensure right messages are delivered CEO briefed by Executive lead Executive lead to contact LA Executives to seek support for expediting discharges/transfers/packages of care GP admissions to MAU /SAU to be staggered Additional nursing and medical staff to attend and support A&E Department Maintain a record of events and actions taken to inform future learning

WAST Triggers:
Clinical and severe weather triggers in blue bold are weighted as 2

Red performance is below 65% for four weeks or <60% for three consecutive days
19 minute backup standard <95% for 8 weeks
> 20% of Green 3 calls waiting continually in excess of 20 minutes
Activity is >15% above forecast per Health Board(s) area
Ambulance handover delays are reaching 45 minutes in any given hospital
999 calls being answered < 6 seconds < 75%
Request to provide mutual aid to other ambulance services
Failure of critical system CAD, CAS, GRS, MDT, phone, radio for more than 2 hours
Severe weather forecast within next 24 – 48 hours
Unit hours provided are <90% against requirement
CCC staffing is < 90% against requirement
NHSD staffing < 90% of planned
Significant event or incident expected to impact on demand is planned in next 24 hours

WAST CCC Actions:	
Clinical desk or NHSDW nurse to transfer suitable Green 1 calls for nurse telephone assessment	Clinical desk staff, Consultant Paramedic, Duty Control Manager, Head of CCC, Senior Nurse Advisor, Medical Director
Clinical desk or NHSDW nurse to consider advising allocator to stop dispatch of individual ambulance resources prior to Green 1 calls reaching a final disposition	Clinical desk staff, Consultant Paramedic, Duty Control Manager, Head of CCC, Senior Nurse Advisor, Medical Director

Clinical desk or NHSDW nurse to transfer suitable local Red 2 calls for nurse telephone assessment (VPH only) (Allocator must continue to dispatch available resources to Red 2 calls until nurse confirms alternative disposition) Consider reducing flow of 0845 calls into WAST and ensure demand management processes are appropriately implemented Task PCS crews where possible to support discharges, transfers and routine work Consider deployment of LM/CTL/On Call Manager to affected A&E departments Report all unplanned mid shift finishes to LM and CTLs	Clinical desk staff, Consultant Paramedic, Duty Control Manager, Head of CCC, Senior Nurse Advisor, Medical Director Senior Nurse Advisor, Assistant Nurse Director, Medical Director Duty Control Managers, Allocators, PCS allocators, Utilisation Managers, Clinical Desk Staff Duty Control Managers, Allocators Duty Control Managers, Allocators
Operational Actions: Review all CTL out of rota time Consider increasing operational performance meetings to two per day Consider withdrawal and utilisation of event cover and passing work to VAS Consider rescheduling training and impact on compliance with statutory and mandatory trajectory Contact staff for additional overtime shifts Offer overtime to UCS and PCS crews to support hospital discharges / hospital transfers / routine work Consider offering extended hours for fleet and support services Consider extended use of VAS Consider providing fleet assistants and dynamic support at hospitals for cleaning and stock replenishment Cancel non essential study days Retask trainers to provide operational support where training courses are rescheduled Review availability of all RCMs	 Head of Resourcing, Heads of Service Heads of Service, Head of CCC, Head of Resourcing Heads of Service, Director of Service Delivery, Head of Resilience Heads of Service, Head of Training, Director of HR and OD Head of Resourcing, Resource Teams Head of Resourcing, Resource Teams Head of Resourcing, Executive Team Head of Resourcing, Heads of Service, Director of Service Delivery Head of Resourcing, Head of Training, Director of HR & OD Head of Resourcing, Head of Training, Director of HR & OD Executive team, Heads of Service
COMMUNICATIONS: Health Board: Executive Lead; General Managers; On-Call Managers; Operational Managers; Senior A&E Team; Bed Managers; Ward Managers; Clinical teams; OOHs site managers; Primary Care locality teams; OOHs providers; local authority Chief Executives; Welsh Government (Director of Operations) **WAST:** Duty Manager; Senior Nurse Adviser; Ambulance Liaison Officers; PCS Customer Services Manager; Locality Managers; Heads of Service ; Staff side; HR; Training; On call team; Communications team; Executive Team; Resource Team; CCC management team; PCS Control Managers	

<table>
<tr><th colspan="2">ESCALATION LEVEL 4 – RED: EXTREME PRESSURE</th></tr>
<tr><th>TRIGGERS</th><th>ACTIONS – IN ADDITION TO LEVELS 1, 2 AND 3, THE FOLLOWING ARE REQUIRED</th></tr>
<tr><td>HEALTH BOARD -4 CORE TRIGGERS APPLICABLE: Emergency admissions have significantly exceeded predicted levels and available capacity >12hour breaches have occurred A&E capacity unable to meet further demand Ambulance patients – transfer of care > 60 minutes Patients waiting more than 4 hours for first contact with assessing clinician (majors & minors) No transfers or discharges taking place No CCU or ITU capacity available All planned admissions have been cancelled Unplanned uncommissioned additional capacity in use No divert to neighbouring Health Boards in place</td><td>HEALTH BOARD: The situation has been escalated to the Chief Executive / Director of Operational Planning. Welsh Government colleagues advised of situation Executive Lead is now managing the situation. Activate agreed divert options to neighbouring health boards (To be reviewed in 2hrs); All admitted electives who have not undergone surgery to be cancelled and sent home; Cancel elective activity for the next 24 hours; Set up an onsite Situation Control Group to take tactical control and address significant issues through a series of extraordinary actions over and above those contained in the normal business continuity plans; Maintain a record of events and actions taken to inform future learning.</td></tr>
<tr><td colspan="2">WAST Triggers:
Clinical and severe weather triggers in bold are weighted as 2

Red performance falls below 65% for at least eight weeks, or 55% for three consecutive days
Ambulance handover delays are reaching 60 minutes in any given hospital
Hospital 'diverts' are in place across LHB areas (as per National definition)
Extended period of severe weather causing widespread disruption
Waiting times for nurse triage of calls continuing to rise, 20% of Green 3 calls waiting continually in excess of 30 minutes standard for Nurse telephone assessment
Activity is >20% above predicted volume
CCC calls answered within 6 sec is < 70%
Providing extensive (more than twenty vehicles) or prolonged mutual aid to another service
2 or more critical systems not available at the same time ;CAD, CAS, GRS, telephony, MDT or radion
Defect(s) identified in fleet requiring large number of vehicles to be immediately withdrawn from service for a prolonged period
Prolonged notable incident lasting over 24 hours
Forecast severe weather conditions impacting on ability to respond
EMS Staffing <85% of requirement
CCC staffing < 85% of requirement
NHSDW staffing < 85% of planned
Significant event expected to impact on demand is happening now</td></tr>
<tr><td>WAST:
CCC Actions:</td><td></td></tr>
<tr><td>Director of Service Delivery/Head of Service to host immediate Senior Team Meeting</td><td>;Director of Service Delivery, Heads of Service</td></tr>
<tr><td>All inter hospital transfer activity to be transferred to PCS, UCS or VAS</td><td>Head of CCCs, Consultant Paramedic, Medical Director, Allocators, Head of Resourcing, Clinical Desk staff</td></tr>
<tr><td>Maximise use of PCS for transport of appropriate green calls</td><td>Head of CCCs, Utilisation Managers, Duty Control Managers, Clinical Desk Staff, Consultant Paramedic</td></tr>
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Maximise use of taxis to move patients and staff	Duty Control Managers, PCS allocators, Utilisation Managers, Clinical Desk Staff, Consultant Paramedic, Locality Managers
Consider nurse support in C&W and N control rooms	Head of CCC, Senior Nurse Advisor, Assistant Nurse Director
Clinical desk or NHSDW nurse to transfer suitable Green 1 calls for nurse telephone assessment	Clinical desk staff, Consultant Paramedic, Duty Control Manager, Head of CCC, Senior Nurse Advisor, Medical Director
All NHSDW pass backs to remain 1 – 4 hour response	Head of CCC, Utilisation Managers, Duty Control Managers, Allocators
Allocator to stop routine dispatch of ambulance resources to Green 1 calls where on site nurse support is available	Clinical desk staff, Consultant Paramedic, Duty Control Manager, Head of CCC, Senior Nurse Advisor, Medical Director
Clinical desk or NHSDW nurse to transfer suitable Red 2 calls for nurse telephone assessment where on site nurse support is available	Clinical desk staff, Consultant Paramedic, Duty Control Manager, Head of CCC, Senior Nurse Advisor, Medical Director
Clinical desk or NHSDW nurse to consider advising allocator to stop dispatch of individual ambulance resources prior to a Red 2 call reaching a final disposition where on site nurse support is available (Allocator must continue to dispatch available resources to Red 2 calls unless nurse confirms an individual resource may be stopped)	Clinical desk staff, Consultant Paramedic, Duty Control Manager, Head of CCC, Senior Nurse Advisor, Medical Director
All GP Green 3 calls time to be extended to 4hrs minimum	Duty Control Managers, Call takers, Head of CCC, Medical Director
Consider cancelling all AS3 (hospital transfers), unless they are essential critical care requests by lead clinicians	Head of CCC, Utilisation Managers, Duty Control Managers
Consider Quality Support team to be established in Clinical Contact Centre	Director of Service Delivery, Heads of Service
Appropriately trained staff to be available to answer calls	Head of CCCs, Utilisation Managers, Directorate Management Teams
Contact all relevant external stakeholders to inform of level	Duty Control Managers
Operational Actions:	
Consider contacting staff of duty to request support	Head of Resourcing, Resource Teams
Review opportunity of accessing additional capacity across the Trust, including HART Team	Head of CCC, Heads of Service, HART Manager, Medical Director, Director of Service Delivery
Consider cancelling all meetings other than those called by Directors	Executive Team, Heads of Service
Media campaign to highlight situation both externally and internally	Head of Communications
Consider cancellation of all event cover	Heads of Service, Head of Resilience, Head of Resourcing, Director of Service Delivery
Reduce PCS work being undertaken	Heads of Service, Customer Service Managers, PCS Allocators
Offer out all shifts on overtime	Head of Resourcing, Resource Teams
Review planned leave and negotiate rescheduling with staff	Head of Resourcing, Resource Teams, Heads of Service, Line Managers
Consider rescheduling of some/all training	Head of Resourcing, Heads of Service, Firector of OD & HR, Head of Training
Consider recall of all seconded staff	Directors, Heads of Service
Ensure drivers available to support vehicle moves	Head of Resourcing, Directorate Management Teams
Consider cancellation of PCS non urgent out patient work and prioritisation of discharges to support EMS	Head of Resourcing, Fleet Managers Heads of Service, Utilisation Managers, PCS Allocators, Customer Service Managers

COMMUNICATIONS: Health Board: Executive Lead; General Managers; On-Call Managers; Operational Managers; Senior A&E Team; Bed Managers; Ward Managers; Clinical teams; OOHs site managers; Primary Care locality teams; OOHs providers; local authority Chief Executives; Welsh Government (Director of Operations)
WAST: Duty Manager; Senior Nurse Adviser; Ambulance Liaison Officers; PCS Customer Services Manager; Locality Managers; Heads of Service ; Staff side; HR; Training; On call team; Communications team; Executive Team; Resource Team; CCC management team

LEVEL 5 – CRITICAL –(i.eMAJOR INCIDENT/BUSINESS CONTINUITY INCIDENT)
WAST Trigger
Where the delivery of business as usual is disrupted due to a critical incident, major incident or business continuity incident:- A business continuity incident is an internal threat or occurrence, or an external one which has a serious impact on the ability of the Trust to continue its business activities. A major incident is a large scale incident for which normally available resources are insufficient to manage the incident without significant additional resources or mutual aid and involving significant multi-agency co-operation. A critical incident is any incident where the effect of response is likely to have a significant impact on the confidence of patients or their families In order to move to this level a BCI or MI must must be formally declared by WAST. Where another agency or stakeholder i.e.LHB declares a BCI or MI and the Trust is supporting or impacted on by the incident movement to this level may also be considered

WAST ACTIONS: **In addition to the actions taken at Levels 1, 2, 3 and 4, the following are required:**	
The situation has been escalated to the Chief Executive and Chair	Director of Service Delivery, CEO
The situation has been escalated to the Trust Board	Corporate Secretary
Consider implementation of Major Incident or Business Continuity Plan	Director of Service Delivery
Ensure access to the resources required to respond and support staff flexibly	All Directors
Field Ops:	
Use non operational managers to provide WAST presence at hospitals	Executive Team, Directorate Management Teams
Response capable staff to support operational response	Heads of service, Directorate Management Teams, Head of Resourcing, Resource Teams
Consider suspension of all training/secondments and projects	Head of Resourcing, Head of Training, Director of HR & OD, Heads of Service Director of Service Delivery, Heads of Service, Staff side
Consider providing refreshments to staff on duty in all areas	All Directors and senior managers
Reschedule all non incident or critical meetings	All Directors and senior managers
Consider 24/7 leadership and support structure	Heads of Service, Directors
Demand:	
Prioritise a response to Red 1 and 2 calls only, all remaining 999 calls will only be allocated a response following clinical assessment	Head of CCC, Medical Director, Assistant Nurse Director, Consultant Paramedic, Clinical Desk Staff
Consider stopping all PCS activity except Renal, Oncology and Discharges	Medical Director, Consultant Paramedic, Assistant Nurse Director, Head of CCC, Heads of Service, Customer Service Managers, PCS Allocators
Review all current leave and negotiate rescheduling with staff	Head of Resourcing, Resource Team, Heads of Service, Locality Managers, Line Managers
Develop media campaign to highlight immediate situation both externally and internally	Head of Communications
CCC:	
Consider suspension of all training/secondments and projects	Head of Resourcing, Head of Training, Director of HR & OD, Head of CCC
Request support from VAS for transport to hospital for patients assessed by WAST Clinicians	Director of Service Delivery, Director of HR & OD, Staff side Head of Resourcing, Medical Director, Consultant Paramedic
Consider suspension of automatic compulsory stand down facility in rest break policy and implement revised appropriate break arrangements	Director of Service Delivery, Head of CCC, Staff side
Consider prioritising 999 over 0845 activity and temporary suspension of 0845 service	Medical Director, Nurse Director, Assistant Nurse Director, Consultant Paramedic, Senior Nurse NHSDW
Clinician in CCC:	
Determine response priorities of "polling" calls. Clinical safety or workload transfer to other agencies where appropriate	Medical Director, Assistant Nurse Director, Clinical Desk staff, Consultant Paramedic, Head of CCCs

WAST COMMUNICATIONS: **Welsh Ambulance Service:** Chief Executive Trust Board Executive Team Medical Director Director of Service Delivery Senior Management Team Resource On call teams Ambulance Liaison Officer PCS Customer Services Manager Locality Managers Heads of Service **Welsh Ambulance Service to engage with and inform:** Welsh Government LHBs GPs Other UK ambulance Trusts Other emergency services LRFs **Media** Provide information and media support	

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LEVEL 6 – POTENTIAL SERVICE FAILURE (i.e. Enduring and sustained BCI or pandemic)	
WAST Trigger	
Enduring or sustained Major Incident, Business Continuity Incident, critical incident which is not likely to cease having an impact on the delivery of the service in the next 48 hours	
WAST ACTIONS **In addition to the actions taken at all previous levels, the following are required: -**	
Field Ops:	
Consider deployment of clinical staff with a non clinical driver (PCS VAS etc)	Medical Director, Consultant Paramedic, Head of CCC
Review HART/HEMS deployment	Medical Director, Consultant Paramedic, HART Manager
Use UCS staff as First Responder on solo vehicles on a voluntary basis	Medical Director, Consultant Paramedic, Head of CCC
Consult with staff and staff side on the management and allocation of annual leave booked over the coming weeks	Director of HR & OD, Head of Resourcing, Director of Service Delivery, Staff side
Consider outsource fleet servicing	Head of Resourcing, Fleet Managers
Consider access to locum agencies for paramedic and other clinical staff	Medical Director, Director of Workforce and OD
Consider redeployment of all staff to secondary roles to support protracted incident or event	All Directors and senior managers
Consider geographical location of all staff and resources to support protracted incident or event	All Directors and senior managers
Demand:	
Prioritise a response to Red 1 and 2 calls only, all remaining 999 calls will only be allocated a response following clinical assessment	Head of CCC, Medical Director, Assistant Nurse Director, Consultant Paramedic, Clinical Desk Staff
Consider stopping all PCS activity except Renal, Oncology and Discharges	Medical Director, Consultant Paramedic, Assistant Nurse Director, Head of CCC, Heads of Service, Customer Service Managers, PCS Allocators
Review all current leave and negotiate rescheduling with staff	Head of Resourcing, Resource Team, Heads of Service, Locality Managers, Line Managers
Develop media campaign to highlight immediate situation both externally and internally	Head of Communications
Control:	
Request additional clinical support from LHBs to assist with the clinical assessment and prioritisation	Medical Director, Consultant Paramedic, Head of CCC
Implement recorded message advice where possible	Director of Service Delivery, Head of CCC, Medical Director, Consultant Paramedic
Recall all relevant secondments	Head of Resourcing, Resource Team, Directorate Management Teams, Executive Team

Identify staff for national ambulance co-ordination centre Consider joint working opportunities with other emergency service staff **Clinician in Control:** Use non clinical staff to support clinicians in CCCs	Director of Service Delivery, Director of HR & OD Directorate Management Teams, Executive Team Medical Director, Consultant Paramedic, Head of CCC
COMMUNICATIONS: **Welsh Ambulance Service:** Chief Executive Trust Board Executive Team Director of Service Delivery Heads of Service / Assistant Directors Senior Management Team Resource Duty Officer Ambulance Liaison Officer PCS Customer Services Manager **Welsh Ambulance Service to engage with and inform:** Welsh Government GPs Other UK ambulance services Other emergency services LRFs	