South East Coast Ambulance Service NHS
NHS Foundation Trust

Response Capable Manager Standard Operating Procedure

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1. Scope

1.1. South East Coast Ambulance Service (SECAmb) NHS Foundation Trust is committed to safe high-quality clinical outcomes and providing high quality patient care.

1.2. Response Capable Managers (RCM) are staff in management or leadership roles who may be required to respond to incidents on behalf of the Trust in the following roles/modalities.

1.3. Clinical response to 999 or other calls, and/or.

1.4. Commander response (Operational, Tactical or Strategic) (non-clinical). Command functions are not in scope for this document. Please refer to the relevant documents issued by the Emergency Preparedness, Resilience and Response team.

1.5. A clinical response may be undertaken in a marked trust vehicle or suitably adapted and equipped leased or Trust supplied vehicle. Response in personal vehicles is out of scope for the SOP (see Community/Staff Responder Policy)

1.6. This SOP does not apply to staff employed within front-line operational roles i.e., within roles that operate on shift lines on ambulance resources or specialist operational teams such as HART, or as clinicians within the Emergency Operations Centres or Integrated Urgent Care (NHS111) environments

1.7. This procedure is applicable to eligible staff/managers in the Trust whose role requires them to be an RCM and sets out the scope to which those identified as response capable must adhere in order to contribute to safe and timely care to patients.

1.8. Due the nature of the CCP management deployment model, CCP Clinical Managers are out of scope for this procedure. Deployment of CCP Clinical Managers is covered in the CCP Deployment Procedure.

1.9. The governance principles regarding medicines management apply to all RCMs including response capable CCP Clinical Managers whose model of deploy is described in a separate procedure.

1.10. The specific requirements for eligibility for a lease car with or without blue light/response capability is not in the scope of this document. Please refer to the Lease Car Policy.

2. Principles

2.1. Response capable managers working on a marked Trust vehicle on a planned shift should operate at their optimal scope of practice (or on a reduced scope of practice as part of a return to practice agreement). They should be recorded on GRS as crewing a planned shift.

2.2. RCMs operating in their own leased or Trust supplied vehicles are not considered a fully equipped Trust resource; the agreed RCM standard load list reflects this. RCM availability and attendance at incidents is intended to support patient care, operational performance, staff support and to enhance safety.

2.3. RCMs within a specialism may carry appropriate identified equipment for their clinical grade, but this is not mandated and the standard loading list for RCMs should be considered the minimum equipment carried for patient care. All equipment must be regularly checked/serviced and within use-by dates (see section relating to medicines governance).

2.4. RCMs are required to follow the Medicines Management Policy and relevant medicines procedures regarding any medicines carried as an RCM.

2.5. No additional equipment is to be sourced and/or carried. Where individual RCMs believe that additional equipment should be included in the RCM standard load list, the rationale for this must be evidence-based and taken through the PPG for approval at QGG. Any approved changes will then be included in an updated SOP.

2.6. All equipment issued to a RCM remains Trust property and some items may need to be registered with the Logistics Team (for example, defibrillators) in order for servicing schedules to be maintained.

2.7. Staff in RCM roles should, unless operating within an exemption be "**patient ready**". This means wearing either uniform or appropriate clothing that complies with both Infection Prevention and Control and Health and Safety procedures with PPE available, having functioning communications devices, and with a checked and equipped vehicle as defined in the standard load list.

2.8. RCMs should be booked on with EOC and ensure they can monitor the radio channel in the location they are in and seek to offer assistance where needed.

2.9. EOC should be able to request RCM attendance to any incident where a delay to a patient may cause harm. Similarly, RCMs should be prepared to

respond whilst travelling through the Trust's geography, where workload allows.

2.10. RCMs may need to update EOC with their movements between operational areas to ensure correct visibility on the CAD and optimal auto-allocation.

2.11. As the Trust continues to deploy its workforce in an agile way in response to the Covid-19 pandemic, RCMs should seek to position themselves within their communities and seek to (if possible) work in locations lower in the System Status Plan wherever possible.

2.12. RCMs core employed role should be their focus, however, this procedure seeks to foster a culture of "**patient first**" which will mean accepting that interruptions may impact on others' work. The number of responses undertaken by RCMs will therefore need careful monitoring to ensure that the Trust meets all its regulatory obligations and that governance processes are not adversely affected (i.e., meeting quoracy due to core group member leaving to attend a 999 call). RCMs should also be aware of any stipulation regarding the minimum number of responses and mileage required to retain eligibility for a lease car – please refer to the Lease Car Policy.

2.13. RCMs should respond only to carry out their intended role based on the needs of the incident and their level of training and authority. On the whole, this will be a clinical role, rather than a command role, although senior clinicians will of course provide clinical leadership to colleagues on scene. For example, a clinical manager should attend an incident to provide or support direct patient care. Please refer to any relevant EPRR policies and procedures relating to command roles and functions within the scope of identified RCMs.

3. Procedure

3.1. Clinical Overview

3.1.1. The purpose of being clinically response capable is to provide periods of planned or dynamic resource to support patient care and operational performance.

3.1.2. All members of staff who have a clinical/professional component in their job description must remain clinically active and competent.

3.1.3. Clinicians holding a professional registration are responsible for maintaining their registration and are accountable to their regulator via their published standards (such as CPD, conduct, standards etc).

3.1.4. RCMs should contact a Consultant Paramedic in the first instance where they have concerns about their clinical/professional currency.

3.1.5. In order to promote and maintain currency, staff should ensure they are up to date keys skills training, undertake appropriate CPD and:

3.1.6. Undertake a yearly average of one front-line operational shift every month (12 per year pro-rata), unless agreed with their manager; this should be on a Double Crewed Ambulance or in a grade-specific vehicle. These shifts may form part of the managers clinical supervision...

3.2. Reporting and Audit

3.2.1. The Trust will monitor the activity of RCMs as part of clinical governance and assurance processes in line with the key lines of enquiry to promote the Trust as safe, effective and well-led.

3.2.2. Being response capable means being both clinically current and having the ability to make a response in a marked and/or leased vehicle. This therefore means that RCMs should undertake shifts in marked vehicles, carry out CPD, statutory and mandatory training, and supervision, rather than limiting their clinical exposure to responses in a lease car.

3.2.3. Line managers of Response Capable staff are expected to support a job plan that facilitates meeting these obligations as part of the overarching role brief/job description. This may include the provision of an individual training plan which will be developed and overseen by the Consultant Paramedics to ensure that staff remain clinically capable.

3.2.4. Lease car users with blue lights (either hard-wired or temporary) should follow the guidance in the Lease Car Policy with regards to the minimum commitment in terms of number of incidents attended. It will be borne in mind that for some RCMs their contribution to periods of high demand means working in EOC or a PP Hub and therefore should not be disadvantaged where achieving the minimum number is challenging.

3.2.5. Where the RCM requirements are not met, individuals may be subject to a review of their status as an RCM (including the requirement to be clinically active/registered in their job description).

3.3. **Standard Load List**

3.3.1. RCMs are not expected to operate as a fully equipped single response vehicle. The Trust's expectations are therefore aligned to the limitations of the equipment carried in terms of immediate and necessary treatment of patients and that some patients may need to be attended by a marked Trust resource in order to manage their care on scene (for example, carrying out a 12 lead ECG).

3.3.2. Staff who need to be response capable and have a lease or Trust issued car must be issued with the minimum level of equipment, and this needs to be provided by the Trust. RCMs should liaise with their line manager and/or directorate Business Support Manager to ensure any costs are considered in the overall budget for their lease car (such as response bags/equipment and AED).

3.3.3. The standard load list for RCMs is contained within the main trust load list document which can be found on the Trust Intranet.

3.3.4. RCMs within the Operations Directorate who are based at a MRC/VPP will be able to have their consumables restocked by MROs. Other RCMs will need to restock their consumables themselves at any MRC or VPP. Other RCMs are required to check and maintain their equipment at their local facility (Ambulance Station, VPP, MRC). This position may change in line with future Make Ready contracts.

3.3.5. RCMs who have a specialist role (i.e., Tactical Advisor) requiring additional equipment to be carried will include this in their standard load list.

3.3.6. RCMs should ensure good equipment governance in that the equipment is regularly checked and all items are in date.

3.4. **Medicines**

3.4.1. RCMs may keep a standard POM/GSL drug bag in their vehicle and must follow the Trust Medicines Management Policy to ensure that drugs are kept safely and legally. For example, drug bags must not be exposed to extremes of temperature and an alternative location should be found that is safe and secure and not exposed to extreme temperatures.

3.4.2. Medicines bags need weekly checks to ensure they are in date and should ideally undergo a monthly rotation via their local MRC/VPP. It is the responsibility of the RCM to ensure these checks are completed and the pouches are in date and kept to these standards.

3.4.3. Paramedics may sign out the controlled drugs from a Trust location for a period booked on as an RCM but this is not mandatory or expected and

applies only to the standard working day. The requirement to be on duty to possess CDs reflects both the Trust's medicines policy and published legislation. RCMs who are on-call beyond the end of their working day must not take CDs home once their period of planned duty ends (See next paragraph).

3.4.4. Periods of duty (booked on) should not normally exceed 12 hours and CDs must be kept as per the Controlled Drug Policy and the Controlled Drugs Possession Using Body Worn Pouches SOP. CDs may be possessed only while on duty. This means being booked on the CAD and/or on GRS. CDs **must not** be retained outside the planned shift/working hours, even if the RCM is 'on-call' in a command/manager function.

3.4.5. Extended formulary medicines (excluding Controlled Drugs) associated with specialist practice may also be carried in accordance with the provisions outlined in 3.4.1. Please refer to the relevant medicines governance policy and/or procedure, and the CCP Deployment Procedure relating to CCP Clinical Managers.

3.5. Workload and Wellbeing

3.5.1. RCMs should be aware of their workload and the impact of undertaking responses during and outside of office hours. Incidents attended outside of planned periods of work count towards the overall working week and should not exceed directives on working time.

3.5.2. RCMs may be exposed to a greater proportion of high acuity or sensitive incidents and may also provide clinical leadership at these incidents. RCMs should ensure that they work with their named professional supervisor to review incidents attended and consider their own psychological wellbeing.

3.6. Supervision and Governance for RCMs

3.6.1. In line with the updated Clinical Supervision Procedure, all clinical staff will have a named clinical supervisor. All staff who are patient facing and respond to patients are in scope for clinical supervision. RCMs should understand the requirements and guidance in the Clinical Supervision Procedure.

3.6.2. An individual who has not been patient-facing for an extended period may require additional support to ensure competency required for their qualification level. Response Capable Managers may opt to work at a lower level, for example that of a CFR or ECSW or similar. This will be agreed with the individual's clinical supervisor and line manager, and will be supported by the Medical Directorate, specifically Clinical Education.

An individual training plan may be agreed to support the return to required clinical capability.

3.6.3. Booking on, Being Available and Exemptions (including when you can refuse to attend)

3.6.4. The Trust puts patients at the heart of everything it does and therefore a patient who needs a 999 response should not experience avoidable delays. RCMs will play an increasing role in ensuring patients are attended and assessed in a timely way.

3.6.5. The Response Capable staff member is expected to identify their availability via SMS alerts. Please see the user guide on the service desk for how to use the SMS alerts on CAD. Note specifically the requirement not to use L1/L2/L3.https://servicedesk.secamb.nhs.uk/MSMSelfService/ViewKnownError.aspx?knownErrorId=23&searchString=sms&requestTypeId=0

3.6.6. If you are recognised by the Trust as an RCM, you should be booked on and available during your working hours wherever possible. RCMs have the latitude to decide the level of availability they wish to commit to on any given day, depending on workload and other commitments.

3.6.7. **There are various levels of commitment that an RCM can book on as:**

- **L1:** Category 1 calls
- **L2:** Category 1 and 2 calls
- **L3:** Available for all calls

3.6.8. RCMs should seek to work strategically and aim to place themselves at locations which gives the most value to the trust. For example, a small town with a suitable ACRP (i.e., large enough to work at and leave space for other crew to rest/take breaks) where call volumes are low but performance is hard to achieve.

3.6.9. RCMs should formally book on to the CAD at the start of the period of duty where available and not simple monitor the radio for all calls. This will allow auto-allocation to C1 calls.

3.6.10. RCMs may claim exemptions to being booked on. **These include the following, but is not an exhaustive list:**

- Undertaking Duty of Candour meeting/phone call
- Formal meetings with staff (i.e., appraisals)

- Operational roles which require continuity (i.e., HALO)
- Business commitments out of the region

3.7. **Incident & Shift Types**

3.7.1. RCMs wishing to undertake overtime or planned operational shifts should book these on marked vehicles via Scheduling. In rare circumstances where the Trust is operating at increased surge, the Strategic Commander may authorise RCM overtime for RCMs using their Trust lease vehicle.

3.8. **Escalation Procedure**

3.8.1. In the event of a clinical concern on scene – this should be raised through the relevant clinical desk in EOC.

3.8.2. All Response Capable staff should raise a DIF1 via DATIX as appropriate.

4. Responsibilities

4.1.1. The **Chief Executive Officer** (CEO) is the overarching Executive Lead for the Trust.

4.1.2. The **Executive Director of Operations and Executive Medical Director**, through delegation by the CEO, has overall responsibility for the implementation, operation and local assurance of this procedure. The Executive Director of Operations also has overall responsibility for holding their staff to account for any deviation from this procedure.

4.1.3. The Executive Director of Operations delegates local operational responsibility and accountability for this procedure to the **Assistant Directors of Operations, and Operating Unit Managers (OUMs), Operations Managers (OMs)**

4.1.4. The Executive Medical Director delegates local clinical responsibility and accountability for this procedure to the **Consultant Paramedics, Practice Development Leads and Critical Care Managers.**

4.1.5. The **Executive Medical Director** has responsibility for all aspects of clinical training and development.

4.1.6. The **Chief Pharmacist** supports the Executive Medical Director and Executive Director of Operations providing professional advice with regards all medicines related procedures and practices.

4.1.7. All **Response Capable staff** are expected to operate within their scope of practise and be responsible for identifying any gaps in knowledge.

4.1.8. The **HR Team,** and where applicable, the **Professional Standard Department** will ensure that HCPC (where relevant), eligibility to work, immunisations and DBS checks are completed.

5. Audit and Review (evaluating effectiveness)

5.1. The Operations Business Support Manager will review the active "Response Capable" list quarterly and escalate where the minimum clinical currency standard has not been achieved to the line manager and the active list amended and shared with the EOC.

5.2. For the Strategic, Tactical and Operational on call Response Capable staff, course dates will be recorded, and a register of courses attended will be held by the CP&R/EPRR department. In the event that courses have lapsed, the line manager will be informed, and the rota amended. It should be noted that if stood down from the command rota due to lapsed training this may affect an individual's Terms and Conditions to receive on-call payments.

5.3. The incident reporting system DATIX™ will be reviewed to identify all reported incidents for those identified as Response Capable. This will include the identification of any serious incidents and complaints.

5.4. Line Managers of response capable individuals should seek to ensure that they review RCMs activity against expectation in the following area where data is available, **such as:**

- Number of shifts completed on a DCA
- Number of incidents attended / week
- Categories of incidents attended
- Any Serious Incidents raised
- Any complaints or concerns
- Load Checks
- Qualifications

5.5. A summary report will be shared quarterly retrospectively through the monthly Operational Governance and Performance meetings and EOC/111 Governance Group in the interim through to the Clinical Governance Group.

6. Financial Checkpoint

6.1. This document has been confirmed by Finance to have no unbudgeted financial implications. Or,

6.2. This document has been confirmed by Finance to have financial implications and the relevant Trust processes have been followed to ensure adequate funds are available.