NHS Providers

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ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

A VISION FOR THE NHS AMBULANCE SECTOR

in co-designing urgent and emergency care provision

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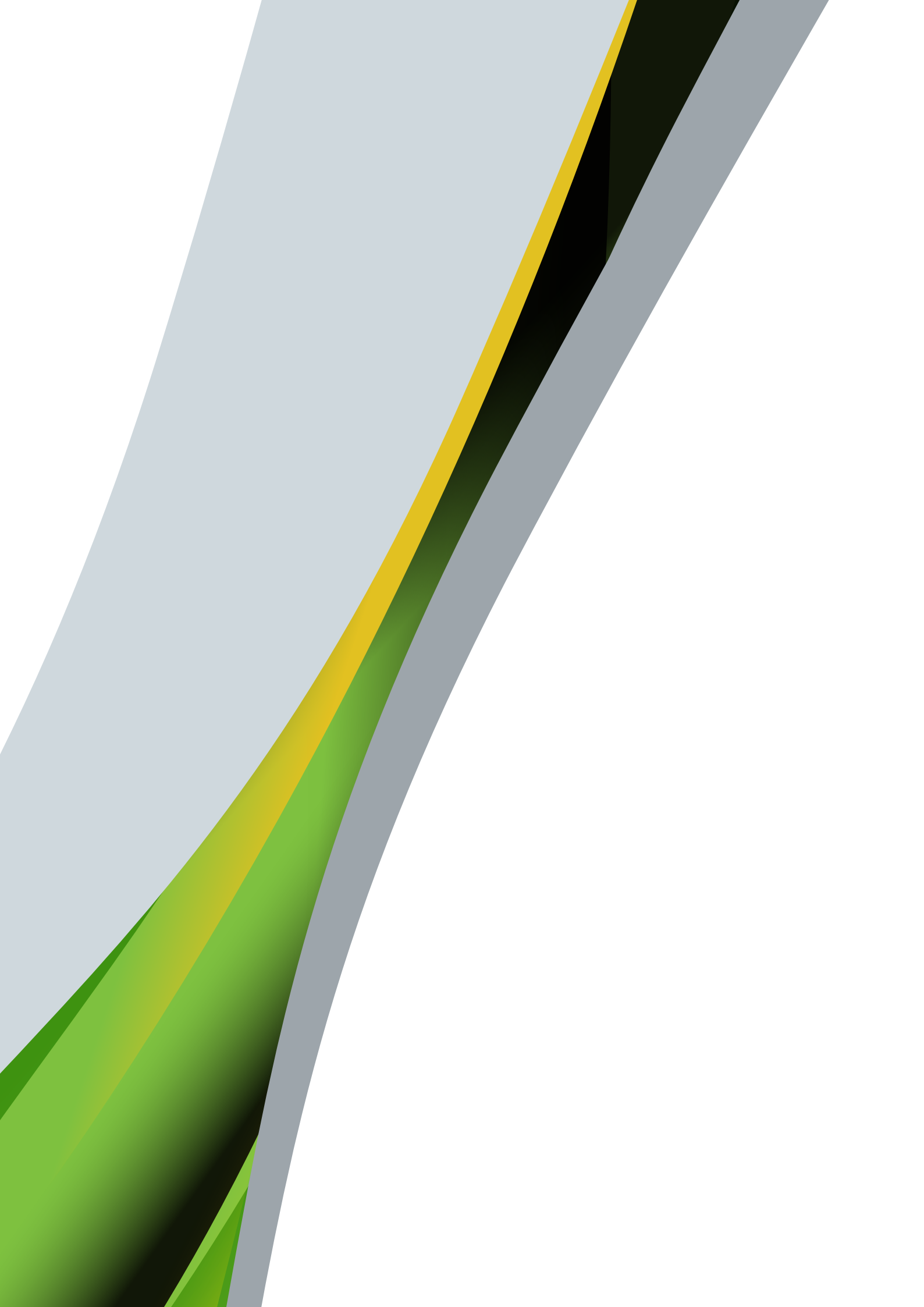

Foreword

This report, developed by the Association of Ambulance Chief Executives in collaboration with NHS Providers and NHS Confederation, highlights the pivotal role ambulance trusts play in delivering urgent and emergency care and sets out a long term vision for an enhanced role they could take in co-designing this care.

We explore the case for change and highlight key case studies that demonstrate the vital contribution that ambulance services are already making by taking on a greater role in leading and coordinating urgent and emergency provision.

This report follows engagement with ambulance, acute, community and mental health trusts as well as integrated care systems and we hope that it serves as a useful conversation starter at system level, to consider the future of urgent and emergency care. It also reflects the close and continuing relationship between our three organisations and our shared commitment to support the work of ambulance trusts and improve care for patients.

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Introduction

The purpose of this paper is to prompt and guide meaningful conversations at national, regional and system level, about the potential for the ambulance service to take a greater role in leading and co-designing urgent and emergency care (UEC) provision.

The core remit of any NHS ambulance service will always be to provide emergency response to those who have a life-threatening health need and to major incidents. However, this is a relatively small proportion of what ambulance services do (circa 10-11%) and is delivered alongside a much greater proportion of responses to urgent care needs in the out-of-hospital environment. In many cases they support other parts of the NHS where there are unmet urgent care needs.

There are clear benefits of the ambulance sector taking on a greater, more consolidated role in UEC provision. These are outlined in this paper, and we have already witnessed where this ambition is turning into reality in various places. However, where it is happening it is mostly by default rather than as part of a system strategy; and where new ways of working and pathways have been introduced, these are often yet to be realised at scale. This might provide certain benefits at local levels but the real possibilities of meaningful change in UEC at regional and national levels are being missed.

This paper sets out a case for change and investment in the ambulance sector. By investing in the ambulance workforce, infrastructure, and digital innovation there is an there is an opportunity to address inefficiencies and make significant progress in meeting the ambitions set out in NHS England's UEC recovery plan,[1] as well as those detailed in the NHS Long Term Plan.[2]

We cannot continue to do more of the same and hope that things will get better. We owe it to patients, as health and care systems, to work together, and we have a moral duty to our people to improve on their current working conditions so they have fulfilled careers and can provide the best possible care. By doing things differently there is the opportunity to fix for tomorrow many of the things that are not working well today.

In thriving systems, leaders view the ambulance service as doing more than responding to emergencies – the service can help to prevent ill health and keep people out of hospital. While pockets of best practice exist, there is now an opportunity for commissioners and partner providers to purposefully discuss with their ambulance service their potential to do more for patients and proactively support other sectors, and in doing so, relieve some of the seemingly intractable system pressures. Where a greater role is appropriate we would welcome collaborative engagement to consider collectively what is needed within a roadmap to achieve this in a realistic timescale for their systems.

1 https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services

2 https://www.longtermplan.nhs.uk

2 The case for change

> ***Anyone who has had recent contact with the NHS knows it is in crisis. Patients suffering long waits and hard-pressed staff working in a system which is not delivering deserve better... The NHS has more money and staff than ever before but has made poor use of it to improve access for patients when they are in urgent need.***
>
> House of Commons Public Accounts Committee HC1336[3]

Health and care systems across the UK have been facing increasing demands and pressures over the last decade, and post-pandemic these have risen to unprecedented levels where avoidable harm is frequently occurring. We know that for many patients their experiences of NHS services are often frustrating, and they have poorer outcomes than could be expected; public satisfaction in the NHS[4] is waning, and exhausted staff are leaving their vocations.

Health and social care provision currently faces:

- a growing, ageing population, living longer with a range of complex conditions[5]
- workforces stretched beyond limits in terms of capacity and poor morale in many sectors, leading to increasing absence levels and problems retaining staff
- access to, and resources in, primary, community and mental health services remaining significantly challenged
- increasing elective waiting lists, with resulting knock-on effects for UEC
- growing delays for discharges from hospital, affecting flow across systems
- crowding in emergency departments, resulting in ambulances queued outside for long periods
- patients waiting unacceptable lengths of time for an appropriate response to their 999 calls.

Ambulance services are at the heart of strained UEC systems and hold some of the biggest risks for patient safety, particularly when there are no resources to send to someone who has called 999 needing emergency or time-critical urgent care. Being available 24/7, patients may contact 999 or 111 because they have been unable to access care through a route they would normally use for their condition (whether in hours or out-of-hours), or because they are unsure of what they need.

3 https://committees.parliament.uk/committee/127/public-accounts-committee/news/198054/postcode-lottery-in-urgent-and-emergency-nhs-care-highlighted-by-pac-report

4 https://www.kingsfund.org.uk/insight-and-analysis/reports/public-satisfaction-nhs-and-social-care-2022

5 https://www.health.org.uk/publications/health-in-2040

They see the ambulance service as a 'trusted brand' and expect to get a response. Sometimes, the ambulance service is not what they need, and they might not need to go to hospital, but there may be no alternative.

Despite best efforts and additional short-term funding for recovery plans, the sector is struggling to make significant sustained improvement in UEC.

We need radical re-design for UEC and long-term planning, with a stronger focus on prevention and a shift in balance of investment to out-of-hospital services. We also need to be better prepared for the emerging impacts of advancing technologies and medical developments, climate change, global conflicts, and the potential for pandemics of any nature. We cannot, as a health service, continue to do more of the same. We all need to do things differently.

> ***The pressures on every part of the system across the board just feel to me to be more challenging than they've ever been. That doesn't mean that there isn't a possible way through this, but it does mean that we really do have to start thinking very differently... the NHS needs to rebalance... sadly, most investment in health care in the last decade, has tended to focus on hospitals, because that's where the noise is.***
>
> Sir David Haslam – *Does the NHS need to be rebooted?*[6]

6 https://share.transistor.fm/s/f77e2fe0

Long-term vision of an enhanced role for ambulance services in urgent and emergency care

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Despite the current challenged position, ambulance services have great potential to help solve some of the key system pressures, reduce the risks for patients and address inefficiencies within their health systems. They are able to make efficient use of scarce multi-disciplinary clinical resources, for example in clinical assessment service (CAS) hubs servicing wider footprints, working with their systems to implement the models of care that make most sense for their particular population needs.

In an NHS that is truly focused on:

- provision of high-quality, timely and integrated UEC
- keeping patients out of hospital when they do not need to be there
- reducing inequalities in access to healthcare
- preventing ill health.

There is greater potential for **ambulance services to develop as trusts assessors, with the following two remits**:

1. The lead coordinator and navigator for access to UEC and support agencies, making efficient use of multi-professional, integrated clinical hubs and assessment services at system level.
2. Responders to patients needing out-of-hospital care, with more direct referral pathways to other parts of the system, and advanced skill sets and paramedicine models to safely keep more patients at home.

By developing a UEC strategy collaboratively with system partners, listening to patients and their communities, ambulance services, with the support of their commissioning bodies, could become system leaders in implementing those strategies, joining up all the elements across sectors.

The potential for ambulance services to play a leading and coordinating role in UEC lies in the fact that they already have:

- **24/7 regional/national infrastructure** enabling them to see issues, gaps, and connections that others cannot, and to exploit the efficiency this offers at a system or regional level
- **highly skilled, increasingly multi-professional workforces**, with a range of skill sets able to triage and operate autonomously in all environments
- **the trust of the public** and interaction with patients in their own environments, and the ability to engage with 'hard to reach' patients
- **little difficulty in recruiting** to the clinical workforce and the ready ability to expand, develop and up-skill our clinicians to specialised and advanced practice levels
- **interoperable telephony and connectivity infrastructure**, supporting the interface with all parts of UEC across primary, secondary, community and mental health care

- **data insight in real time** that can provide early-warning intelligence to systems
- **longitudinal data insights** to support population health management and planning of services
- **standardised national capabilities and resilience** to support each other when mutual aid is needed.

Investment to rapidly increase recruitment to, and development of, our highly skilled paramedics and multi-professional clinical workforce in emergency operation centres and CAS hubs at scale, has the opportunity to offer good value for money and will reap the rewards in getting patients access to the most appropriate care first time. Expanding our digital infrastructure and advanced practitioner roles will mean more patients can be appropriately treated, monitored, and cared for out of hospital, especially older people and those living with frailty.

Paramedics are sought-after professionals, for good reason, and increasingly work in different sectors such as primary care and emergency departments. We need a future strategy that supports paramedics to undertake portfolio working opportunities within the local system, with better coordination of rotational roles across different settings and the ambulance trust as the main employer where appropriate.

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Systems can bring improvements for patients and staff by having their ambulance service:

- being the entry point to UEC services (particularly out-of-hours) where **patients can be triaged once** and navigated to the most appropriate service for their needs
- co-ordinating appropriate face-to-face and remote responses to 999 and 111 calls through seamlessly joined-up **multi-professional clinical assessment services at scale** (ie system level), making efficient use of scarce clinical resources
- providing **timely emergency response** to life-threatened 999 calls and major incidents
- delivering **more extensive and specialised urgent care**, providing paramedicine models with extended mobile diagnostics and prescribing capabilities, able to **safely close more episodes of care in the patient's home** and in our communities
- **supporting primary care and out-of-hours services** in coordinating same-day access to urgent care, by providing telephony and triage support capabilities and infrastructure, ensuring patients receive or are navigated to the most appropriate response to their needs
- extending the application of regional Computer Aided Dispatch infrastructure to provide **dynamic sight of other out-of-hospital UEC resources** such as for mental health and community teams, and provide early warning when demand is likely to exceed capacity
- co-ordinating non-emergency transport for patients needing scheduled care and discharge or transfer from hospital, to **better support patient flow** through systems
- being system players and anchor institutions in population health management, prevention and **reducing health inequalities**
- being the NHS lead in our collaboration with other emergency services and resilience fora, to provide **greater assurance in our preparedness for major incidents** and protracted, challenging events.

By consolidating the role of ambulance services in urgent care coordination and provision in a planned and integrated way (e.g. with same-day emergency care), ambulance services can properly support other out-of-hospital sectors that may struggle with resourcing same-day urgent care provision (i.e. primary, community and mental health).

Ambulance services can reduce pressures on these sectors so they can focus on their non-urgent provision. By safely closing more episodes of care in our communities we can shift the balance away from secondary care, releasing capacity for elective work. This in turn will remove the experience of ambulances being held for long periods outside hospitals, with all the adverse effects for both patients and staff. By having ambulance resources available where and when they need to be we can improve not only emergency responses, but also the out-of-hospital responses from all providers and join up the wrap-around care that patients expect and will benefit from.

4 Case studies

CASE STUDY

The Welsh Ambulance Service NHS Trust (WAST)

Rotational paramedicine model working with primary care

WAST uses paramedicine models across the country, creating benefits for patients and staff, whilst reducing frontline pressures and improving patient flow, particularly in rural areas.

For example in North Wales, advanced paramedic practitioners (APPs) have been working in a rotational model, safely reducing conveyance to Emergency Departments The pool of APPs in this area allows provision of short-term rotations, with them working between WAST and a cluster of GP practices over the course of each week.

These APPs, when responding for WAST to a patient's home, are able to undertake initial observations and treatment and book a follow-up appointment with themselves in the GP practice to ensure continuity of care if a general practice appointment is required. With their advanced skill set a significant benefit from this model is that the APPs can appropriately manage many higher acuity patients. This operational model is seeing a non-conveyance rate 35-40% higher than a regular paramedic crew.

Benefits:

- Reduced need for transportation to secondary care.
- Higher level of clinical skills; therefore patient needs are resolved at first contact, including patients with higher acuity needs.
- Reduced handover times at ED.

CASE STUDY

South Western Ambulance Service NHS Foundation Trust (SWAST)

Care coordination hubs

SWAST operates in over seven Integrated Care Systems, with NHS Dorset as their host system. SWAST has worked with three of their ICSs to test the concept of locating their specialist paramedics within local care coordination hubs.

The care coordination model includes a range of changes aiming to optimise integration between SWAST and a local single point of contact hub, where the embedded specialist paramedics work with multidisciplinary clinicians to manage and respond to category 3-5 calls filtered out of 999 calls. Many of the patients who call 999 are thus managed safely and effectively over the phone and navigated into the most appropriate out of hospital service, without sending an emergency ambulance.

The success of the model is built on the ability of clinicians to make their own judgements and relies on the quality, scope and capacity of community services available. The more referral pathways options there are (including Minor Injury Units, Urgent Care Centres, ambulatory care units), the more conveyance to an ED can be reserved for those patients who require emergency assessment and/or admission.

CASE STUDY

Isle of Wight

Falls response

Falls make up a significant number of 999 calls with many of these not resulting in significant injury to people - however, delays can lead to more harmful impact for patients. Evidence shows that for every hour a patient spends on the floor following a fall, the probability of hospital admittance increases by 10%.

Working in partnership, Isle of Wight Council's Wightcare service and the Isle of Wight NHS Trust Ambulance Service, developed the Wightcare community falls response service. The service is sent to 999 or 111 calls where a person who has had a fall has been clinically assessed by the NHS trust as not requiring an emergency ambulance response.

Those that suffer a non-injury fall receive swifter care, usually within one hour, and do not need to wait for an emergency ambulance. This ensures that local people who have been triaged by medical professionals as requiring a lower category response, are seen and assisted more quickly, and the risk of them coming to harm and needing admittance to hospital is reduced.

CASE STUDY

North East Ambulance Service Trust (NEAS)

Regional integration of 999, 111 and CAS

An integrated regional approach to the commissioning of 999 and 111 services has shown the potential to bring about significant economies of scale and quality improvements across service provision, particularly in relation to call answering, clinical assessment, and triage.

NEAS have been delivering an integrated 999 and 111 service across the whole of the north east since 2012. The CAS is an integral element of the patient pathway and is staffed by multiple clinical disciplines (e.g. nurses, paramedics, pharmacists, and GPs).

NEAS use the NHS Pathways triage system for both 999 and 111 and have the same Computer Aided Despatch system for both. This allows seamless transition, when needed, of patients between the two services. 60% of NEAS call takers and health advisors are multi-skilled to work in both services.

Benefits:

- For the patient, a seamless service between 999 and 111 with access to clinical advice and navigation to appropriate out-of-hospital care when needed.
- Flexibility in call handling resourcing for surges in demand on 999 to be managed effectively.
- Expedient management of the volume of calls transferred from 111 to 999.
- For staff: clear progression from 111 to 999 and greater scope for flexible working.

5 Conclusion

By acknowledging the potential for change and co-designing system UEC strategies with all partners and stakeholders, the ambulance sector can play a pivotal part in helping to alleviate many of the system pressures and capacity issues, rather than contributing to them. By rebalancing the focus of resources in more efficient and effective ways, we can improve out-of-hospital services and experiences for patients. This would also facilitate the development of a more positive culture, supportive and productive working environments for our people. We could create attractive and fulfilling remits and cross-sector career paths for the UEC workforce, and address many of the challenges that are leading to the current levels of dissatisfaction and attrition of one of the NHS's most valuable assets.

The Association of Ambulance Chief Executives, the NHS Confederation and NHS Providers believe that the ambulance sector has much more to offer the rest of the NHS in improving UEC provision in the UK. We would like leaders across the national, regional and system UEC landscape to use this paper as a starting point to explore the possibilities of enhancing the ambulance role within UEC, promoting collaborative cross-sector planning, and implementing a long-term strategy to deliver meaningful change for patients and our people.

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

AACE provides the UK's statutory ambulance services with an organisation that can support them in the implementation of nationally agreed policy. Whether for patient care, operational policy, emergency preparedness, employee wellbeing or volunteering, the Association exists to support its members and to act as an interface, where appropriate at a national level, between them and their stakeholders. More information about the AACE is available at www.aace.org.uk

NHS Confederation

The **NHS Confederation** is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland.

The members we represent employ 1.5 million staff, care for more than one million patients a day and control £150bn of public expenditure.

We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

NHSProviders

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £115bn of annual expenditure and employing 1.4 million staff.

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