

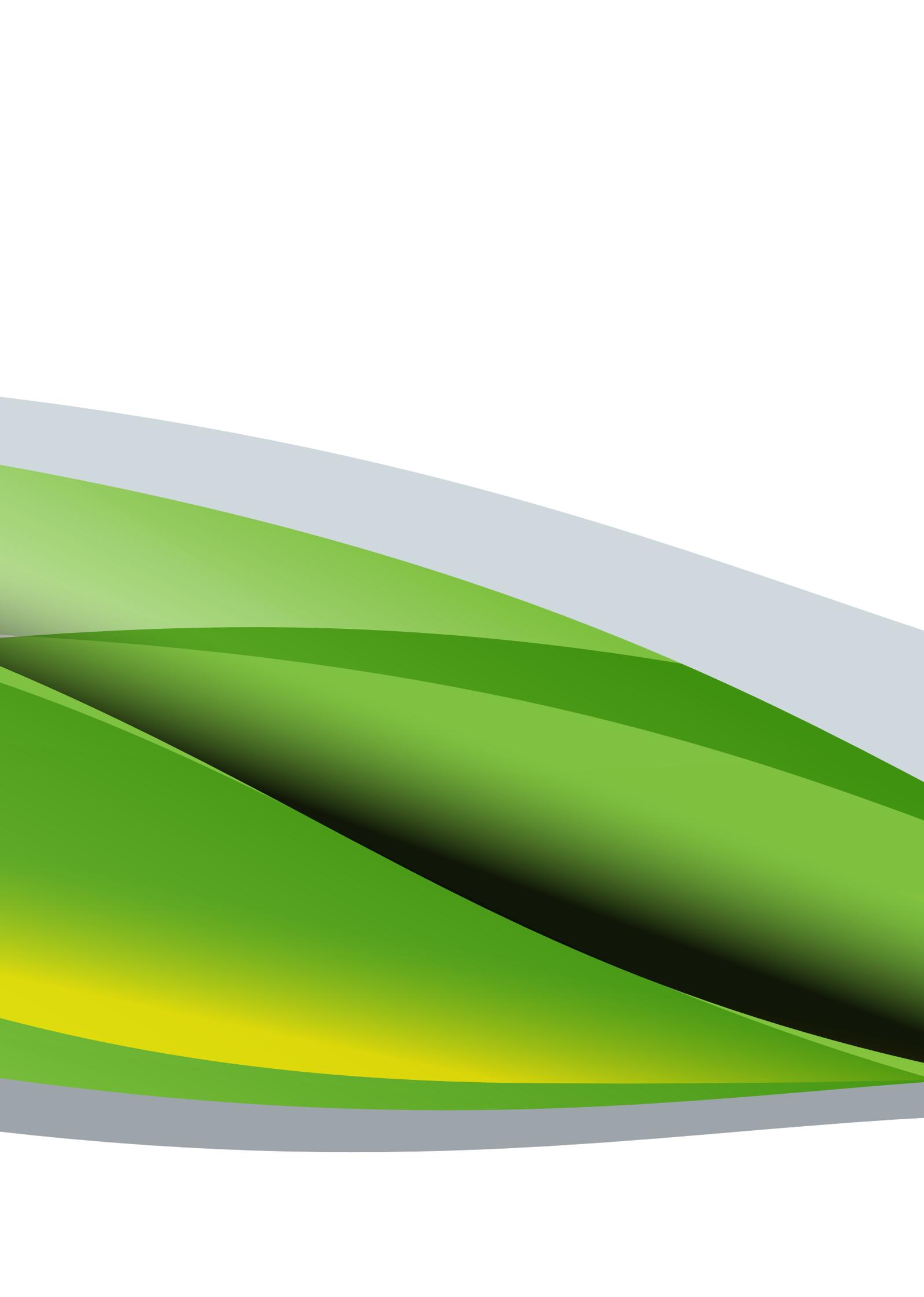


ASSOCIATION OF
AMBULANCE
CHIEF EXECUTIVES

RAPID RESPONSE

**The role of the ambulance sector
in transforming services and
coping with the long-term
impact of COVID-19**

AUGUST 2021



Rapid response

The role of the ambulance sector in transforming services and coping with the long-term impact of COVID-19

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Foreword

This joint report highlights the pivotal role ambulance trusts are playing in managing the long-term impact of COVID-19, transforming urgent and emergency care (UEC) services and delivering the NHS long term plan. As the health and care sector embarks on a further period of significant change to embed system working, and prepare for a new Health and Care Bill, it is clear that the skills, scale and reach of ambulance services mean they are well placed to play a leading role in the integration of services. As the health and care system builds on learning and innovation from the pandemic, the ambulance sector will continue to play a key role in helping to recover care backlogs and meet rising demand for services.

Ambulance trusts continue to face the twin challenges of severe workforce and funding pressures. They have adapted to find solutions, for example by collaborating with partners to provide more care close to home, changing their clinical response model, training and working practices to deploy their staff more effectively, and they are leading the way in harnessing digital technology to improve care for patients. However, we know there is more to do, to work with national decision makers on more permanent funding solutions, and to share best practice across the sector.

In this report we explore these approaches, using case studies to highlight some of the challenges and solutions that demonstrate the vital contribution that ambulance services are already making in integrating care and securing the success of the long term plan. We also look at what needs to happen for the sector's role in this endeavour to go even further, faster.

This report reflects the close and continuing collaboration between our two organisations, with our shared commitment to supporting the work of ambulance trusts, highlighting the challenges they face, celebrating their successes and sharing lessons learned in providing better care for patients in a fast-changing environment.

We are grateful to all who took the time to contribute, and we hope you find it useful when engaging with your local ambulance trust.



Daren Mochrie

Chair
Association of Ambulance Chief Executives (AACE)



Chris Hopson

Chief Executive
NHS Providers

Executive summary

Ambulance trusts are uniquely placed to play a pivotal role in managing the long term impact of COVID-19, transforming services and the delivery of the long term plan. They make a particular contribution through their role as care navigators in driving integrated care, deploying innovative workforce models and enhancing patient care using digital approaches. This will result in more patients being managed in the right place at the right time. With appropriate support, recognition and investment, there is potential for the sector to do even more across and within integrated care systems (ICSs).

The ambulance service continues to face intense pressures. In June 2021, category one incidents increased by 8.1% compared to the previous month. Compared to two years ago, before the pandemic, category one incidents have increased by 27.2% and overall activity has increased by 11.3%. The sector is proving resilient in the face of these increasing pressures, including rising demand for services outpacing funding increases and workforce capacity, and the knock-on impact of very pressured primary and social care services. Trusts are rightly adapting the way they work to meet the increasing demand, in line with the long term plan's vision, but they need parity in investment if this is to be sustained. Prior to the pandemic it had been identified that the sector needed some **£250m of additional funding** to deal with increasing demand and eliminate historic underfunding for some trusts. While they have proven to be resilient and innovative throughout the pandemic, these underlying funding issues remain and must ultimately be addressed if ambulance trusts are to fully realise their potential.

As part of the evolving policy landscape relating to ICSs, ambulance trusts must be involved in regional, ICS and place-level decision making about service design, including defining what single point of access means in practice and over what size footprint. AACE has developed a **blueprint model** which sets out this joined-up approach in more detail. Without this, we risk fragmenting services and duplicating resources through multiple points of access within regions. It is vital that this is recognised as part of the ongoing work to agree how ICSs will function as statutory bodies as of April 2022. AACE is currently engaging with NHS England and NHS Improvement and ICS leaders to explore the concept of a single regional commissioning board with oversight for ambulance services working across multiple ICSs.

Learning from the COVID-19 response has shown that there are opportunities to improve productivity and efficiency when aspects of service provision can be done collaboratively, at scale, across ICS and multi-ICS footprints. Ambulance trusts are well-placed to participate in, and lead, provider collaboratives at system level where it makes sense to do so. Trusts have highlighted the benefits of provider collaboration and partnership working as particularly relevant for the ambulance sector, where demand can be so significantly impacted by wider system issues. Ambulance trusts are already engaged in system working to varying degrees, and all are keen to realise the full value of their contribution in UEC provision and population health management.

Integrated care

The NHS is clear on its ambition to provide patients with the care they need as close to home as possible and reduce pressure on hospital services through reforming how urgent care is organised and delivered. Ambulance trusts already deploy 'hear and treat' and 'see and treat' response models, which have been particularly relevant during the pandemic in keeping people out of hospital wherever possible. Many ambulance trusts are working in partnership with other providers and commissioners in their region to deliver integrated services, with the clinical assessment service (CAS) model forming a central part of this. This means that resources are not duplicated and patient flow is streamlined, leading to a better patient experience.

The ambulance sector's full potential to support elective recovery and measures to tackle the care backlog should be realised. Non-emergency patient transport services (PTS), some of which are provided directly or coordinated by ambulance trusts, support the smooth-running of the healthcare system. These services ensure that patients arrive on time for their appointments and that, when being discharged, they can return home quickly. The move to system-working provides an opportunity for larger system-wide PTS contracting or coordination, which will play a key role in patient flow and tackling the care backlog through efficient use of resources across systems and regions. It will also help to tackle health inequalities by supporting patients who need help to access care.

Innovative workforce models

Ambulance trusts are making changes to training and working practices so that paramedics can develop and learn alongside other types of healthcare professionals and therefore be deployed differently, leading to a reduction in hospital conveyance rates. One such model is rotational working, whereby specialist and advanced paramedic practitioners rotate between clinical settings across systems, using their advanced clinical assessment skills to help provide the right response the first time. Wider use of the model could have a positive impact on patient experience and workforce retention – this is particularly relevant to the development of paramedic roles within primary care networks. The paramedic workforce is scarce however, and the recruitment and positioning of these skillsets need to be considered within ICS multi-professional workforce planning so that the ambulance workforce is not further depleted, especially of the most experienced paramedics.

The long term plan made welcome commitments to build the capability of ambulance staff to respond to patients presenting with mental health issues. This commitment must be adequately resourced in order to increase capacity in the system as the number of people requiring mental health support continues to rise. Mental health expertise within the ambulance workforce is particularly important given that emergency departments (EDs) are not always the most appropriate place for people in a mental health crisis. Adapting response models and working closely with community mental health teams to avoid unnecessary conveyance to hospital for people with mental ill health is, therefore, an important current focus for ambulance trusts.

Digital transformation

The response to COVID-19 has accelerated digital ways of working, leading to: better sharing of medical records and therefore faster clinical decision making, greater collaboration between services, including use of video consultation to enable paramedics to provide care remotely, reducing unnecessary admissions and virus transmissions, and wider use of innovative ways of working, such as 111 First, to ensure seamless clinical handover for patients who need to visit ED. For ambulance trusts covering several ICSs and working with every part of the health and care sector, the gains from digital transformation will be significant: better service coordination, a reduction in avoidable waits and better response times.

Key asks of government and the national NHS bodies

With the right measures and investment in place, the ambulance sector's role in supporting COVID recovery and delivering the long term plan can be developed to its full potential, to the benefit of the whole health and care system and the patients it serves. AACE and NHS Providers are therefore calling for:

- **Policy alignment, ensuring the voice of the ambulance sector is involved in strategic decision-making at national, regional, ICS and place level.** This includes: continued meaningful engagement with the sector on evolving ICS guidance and joined-up workforce planning, wider promotion of the rotational paramedic model in a measured way, and involvement of the sector in policy developments for primary care and social care which impact UEC.
- **Greater recognition of the ambulance sector's role as providers of UEC, with many care episodes being concluded, either on-scene or over the phone, without the need for onward referral, and as care navigators, ensuring people are treated in the right place at the right time.** This includes: recognising the service's role in integrating UEC provision across larger footprints, whilst supporting local, place-based care, acknowledging the unique insight of ambulance trusts on the impact of service reconfigurations and scaling up best practice across a region, and understanding the important contribution of the paramedic workforce in the next iteration of the NHS People Plan.
- **Whole system investment to build on learning from the pandemic, to match the ambition set out in the long term plan, and to address historic underfunding,** in the form of: dedicated mental health funding reaching the services that need it most, a long term, fully costed and funded, workforce plan in the next comprehensive spending review (CSR) that takes into account the needs of the ambulance sector, a multi-year NHS capital settlement in the CSR, in line with NHS Providers' #RebuildOurNHS campaign asks, to unlock capital investment to support further digital transformation and specific fleet requirements.

Introduction

The COVID-19 pandemic has highlighted the pivotal role of the ambulance sector in not only responding to emergency pressures but also acting strategically to alleviate pressures on the wider healthcare system. Ambulance staff and trust leaders have worked incredibly hard to accelerate change and adopt new ways of working while dealing with the intense demands of the frontline pandemic response. This has included huge strides in digital and remote services, recruiting and training additional staff and volunteers, and partnership working.

As the sector moves on to address living with COVID-19 in the longer-term and recovery from the pandemic, including managing the huge care backlog, it is vital that health and care systems lock in learning and the beneficial changes from new ways of working and integrated approaches to care delivery involving ambulance services.

Prior to the pandemic, the NHS long term plan set out a number of ambitions for ensuring the NHS is fit for the future and consolidated the expectation that local partners would increasingly plan and work collaboratively within ICSs (NHS England and NHS Improvement, January 2019). Increased system working, new care models and a system focus on avoiding costly inpatient care have already led to an expansion of the role of the ambulance service in many areas. As the longer-term impact of COVID-19 is becoming clearer, it is timely to look at the evolving role of the ambulance sector in responding to this, and how much more it has to offer.

Ambulance trusts are uniquely placed to play an instrumental role in COVID-19 recovery and the delivery of the long term plan through local health and care system transformation. Their role in care navigation and ensuring people are treated in the right place at the right time is often less well understood than their direct and very visible role in the UEC response. However, sometimes covering six or seven ICSs, the ambulance service can offer a joined-up perspective at a regional level and help to identify and drive integrated care solutions to the recovery challenge.

This report, jointly developed by NHS Providers and AACE, examines some key themes of COVID-19 recovery and the long term plan. We have selected three areas where the ambulance sector is driving initiatives that align with the priorities set out in the long term plan and the task of recovering the care backlog as rapidly as possible across all services: **integrated care, innovative workforce models** and **digital transformation**. In all of these areas, in addition to emerging and existing best practice, there are some barriers to maximising the full potential of the ambulance sector. We will look at how these barriers can be addressed.

Context of ongoing sector pressures

It is important to note the context in which ambulance services are working. Prior to the pandemic, all providers of NHS services were already feeling the effects of rising demand for services outpacing funding increases and workforce capacity, as well as the knock-on impact of very pressured primary and social care services. Ambulance service provision has **historically been under-funded**, with financial settlements not keeping up with ever-increasing activity, nor reflecting demand and capacity modelling. This has had an inevitable negative impact on patient experience and clinical outcomes, as well as the mental health and wellbeing of ambulance service staff. Dealing with demand pressures when service capacity is not correctly sized leads to knock on effects throughout the UEC system in terms of patient flow, and means development and training programmes are cancelled and innovation is constrained.

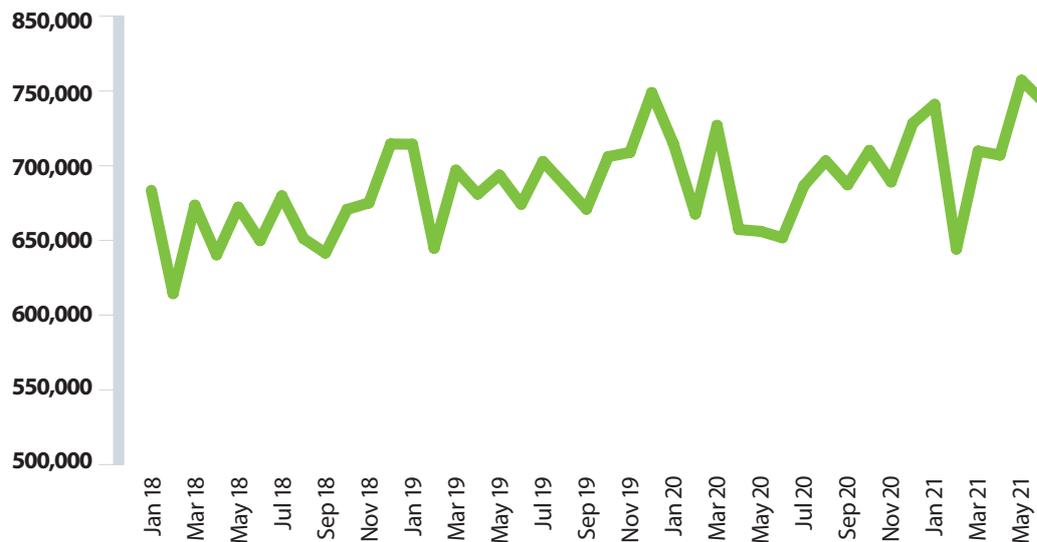
The pandemic has brought with it new challenges, both in relation to the direct COVID-19 response but also in the pent-up demand due to national lockdowns, higher acuity emergency presentations for those whose healthcare has been disrupted, and rising demand for mental health and paediatric care.

Trust leaders have told us of rising pressure on UEC services over recent months and fears about the operational pressures ahead over winter. Increases in demand for lower acuity care indicates that the public are struggling to access healthcare appropriately and this impacts on both 999 and ED walk-in demand. Infection protection and control policies continue to impact capacity and the recent easing of COVID-19 restrictions along with the seasonal impact of 'staycations' have meant that overall demand for services has risen.

Alongside this, trusts continue to face significant financial uncertainty. Due to the impact of the pandemic, NHS budgets were only set for the first half of the 2021/22 financial year – April to September – and the budgets were confirmed just 13 days before the start of the new financial year. At the time of writing, trust leaders are awaiting their budgets for September to March. This makes longer-term planning extremely challenging.

The latest month's activity figures continue to highlight the intense pressure the ambulance service is facing. In June 2021, ambulance category one incidents increased by 8.1% since the previous month to 73,505 (5,523 more incidents). In comparison to a year ago, category one incidents have increased significantly by 62% (28,144 more incidents than June 2020). Compared to two years ago, before the pandemic, this is an increase of 27.2% (15,714 more incidents than June 2019) and overall activity has increased by 11.3%. For the second consecutive month, despite the best efforts of staff, the ambulance service has missed the average mean response time target of seven minutes for category one calls at seven minutes 54 seconds. The average response time for category two calls also continues to deteriorate, missing the 18 minutes target at 30 minutes 42 seconds.

Figure 1
Growth in ambulance sector demand
(total number of incidents)



Specific challenges for the ambulance sector related to increased demand include the following:

- Ambulance trusts cover large geographical footprints and although this enables economies of scale, it can make fast response times, especially in rural areas, a major challenge if resources are not matched to rising demand.
- Emergency care is under particular strain with increased levels of demand in EDs and, as a result, increasingly high rates and lengths of ambulance handover delays, despite the best efforts of staff. In the 12 months to June 2021, more than 115,000 patients experienced a delay in handover at ED of longer than an hour.
- Lengthy delays in handovers continue to cause concern for patient safety, both in respect of those waiting on trolleys in corridors or held on ambulances outside ED, and for patients waiting for an ambulance response to their 999 call.
- Staffing is a major concern, with 1,080 (1.9%) vacancies across the sector, high rates of burnout, and the added risk of trusts losing their most experienced paramedics to primary care networks (PCNs). While trusts are starting to see the benefit of increased paramedic numbers coming through university, these numbers are constrained by the lack of clinical placements available, so intakes remain insufficient overall.
- The impact of relentless demand increases on top of the pandemic is taking its toll on staff wellbeing and attrition of more experienced staff remains a real challenge.

And yet, the sector has continually demonstrated its resilience, with trusts showing they are ideally placed to integrate care alongside system partners, through working across NHS 111, social care, primary care and other settings, reducing rates of avoidable conveyance to hospital. There has also been a concerted drive by the sector to respond to rising demand for mental health services, as illustrated in one of the case studies in this report.

The ambulance sector, COVID-19 recovery and the NHS long term plan

As the longer-term impact of COVID-19 becomes clearer, ICSs and providers face the task of recovering the care backlog over the next two to three years while simultaneously delivering on the original vision of the NHS long term plan and successfully navigating an evolving legislative and policy landscape relating to integrated care. Service transformation will be a key part of this journey, resuming the themes of the long term plan, including a strong focus on the prevention agenda and ensuring that care is delivered as close to home as possible. The pandemic has served to accelerate transformation in some areas such as the digital agenda and workforce flexibilities. It is important that this transformation is now sufficiently resourced on a long-term basis.

There is a risk that attention is focused on recovery and transformation within acute settings but all types of provider across ambulance, community, mental health and acute settings will play a key role in this task. There is also a risk that recovery efforts are focused on elective care while not fully addressing the wider post-COVID impact of delayed treatment and long COVID. For ambulance services, the recovery task will include improving patient flow in and out of hospital via effective patient transport services, paramedic referral to same day emergency care initiatives, and using alternative care pathways and digital tools to safely reduce avoidable conveyance to EDs. This will reduce the overall pressure on hospital services.

Concerns that were raised when the long term plan was originally published have renewed relevance in the fiscally-constrained period following the pandemic. These concerns related to uncertainties around pace of progress in the context of financial and workforce constraints and the lack of a solution to the ongoing social care crisis. The forthcoming autumn spending review should help to provide much-needed clarity on how the government is responding to these concerns. In the meantime, the ambulance sector is already playing a crucial role in the delivery of a raft of priorities set out in the long term plan and the learning from these new ways of working is hugely relevant in the context of recovering the care backlog.

The ambulance sector and system working

As part of the evolving policy landscape relating to ICSs, there is an opportunity to harness the regional knowledge and experience of ambulance services to scale up best practice and transform services. Best practice examples showcased in this report include integrated CAS, remote video triage, specialist paramedics signposting to local pathways, paramedic rotation, and PTS coordination.

In ongoing work to agree how ICSs will function as statutory bodies as of April 2022, AACE is currently engaging with NHS England and NHS Improvement and ICS leaders to explore the concept of a single regional commissioning board with oversight for ambulance services working across multiple ICSs. It is vital this dialogue continues, alongside conversations at ICS and place level, otherwise we risk fragmenting services and duplicating resources through multiple points of access within regions. Recent NHS England and NHS Improvement [guidance](#) positions the ambulance sector as playing an important role at neighbourhood, place, system and multi-system level.

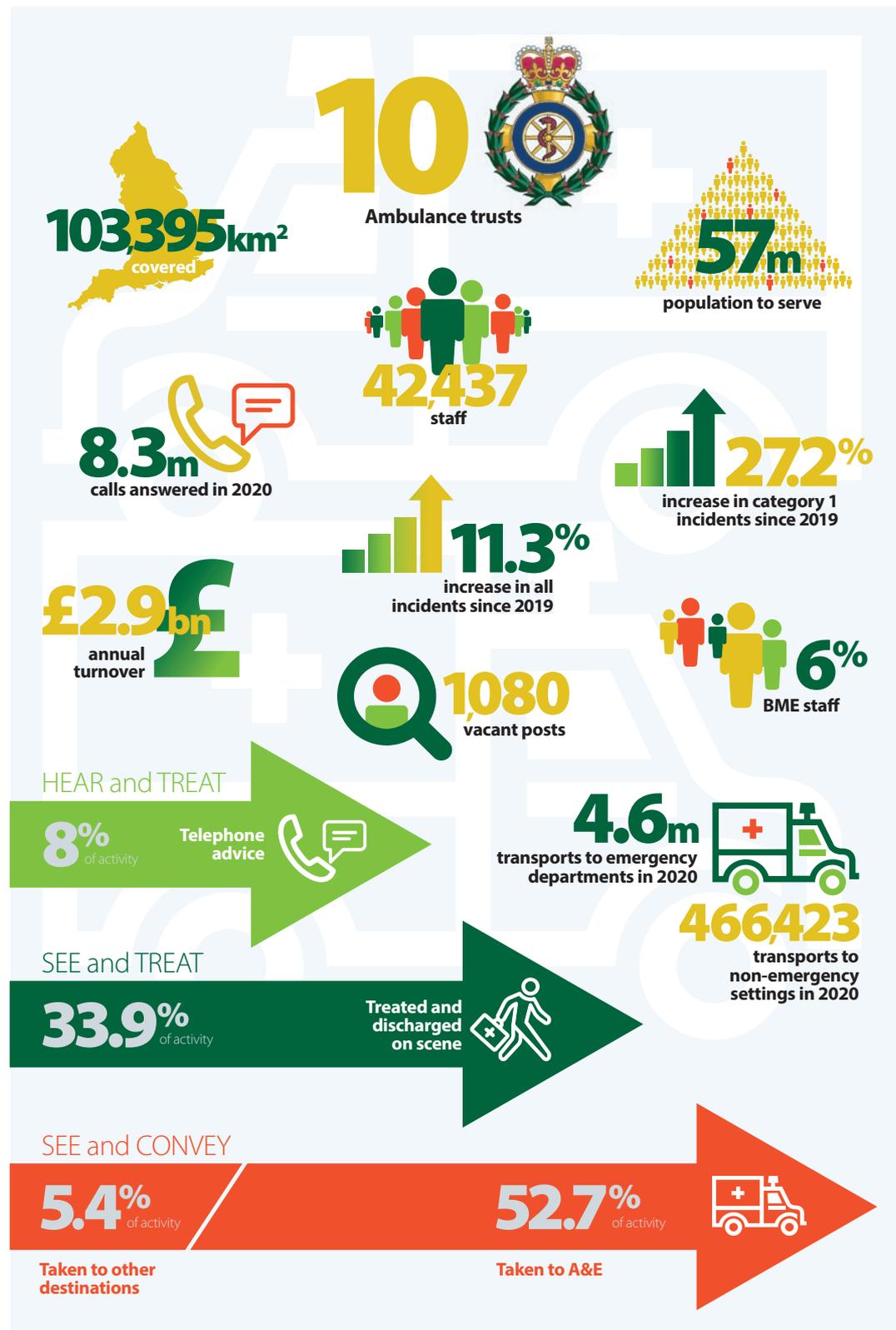
Learning from the COVID-19 response has shown that there are opportunities to improve productivity and efficiency when certain aspects of service provision can be done collaboratively, at scale, across ICS and multi-ICS footprints. Ambulance trusts are well-placed to participate in, and lead, provider collaboratives at system level where it makes sense for them to do so. Trusts have highlighted the benefits of provider collaboration and partnership working as particularly relevant for the ambulance sector, where demand can be so significantly impacted by wider system issues. It is clear that ambulance trusts are already engaged in system working to varying degrees, and all are keen to realise the full value of their contribution in integrated UEC provision and population health management. This is illustrated by the case studies set out in this report, in which we see positive examples of system working leading to improved patient experience and reduced pressure on hospitals.

Going further, faster

There is undoubtedly a vital role for the ambulance sector in COVID-19 recovery, delivering the long term plan and achieving the four key ambitions of system working (improving outcomes, tackling inequalities, enhancing productivity, and supporting social and economic development). It is important, however, to be realistic about the NHS-wide (and social care) issues that need to be addressed in order to capitalise on this opportunity to full effect. We will explore these throughout the report but, in summary, they are as follows:

- policy alignment, ensuring the voice of the ambulance sector is involved in strategic planning and decision-making at national, regional, ICS and place level
- greater recognition of the ambulance sector's role as providers of UEC, with many care episodes being concluded on-scene or over the phone, without the need for onward referral, and as care navigators, so people are treated in the right place at the right time
- whole system investment to build on learning from the pandemic, to match the ambition set out in the long term plan, and to address historic underfunding.

Figure 2
About the ambulance sector in England, 2020-2021



Integrated care

Why is this important?

NHS England and NHS Improvement set out in its 2021/22 *Priorities and operational planning guidance* a key ambition on transforming community and UEC to prevent inappropriate ED attendance, improve timely admission to hospital for ED patients and reduce length of stay. This includes ensuring the use of NHS 111 as the primary route to access urgent care (NHS 111 First), safely reducing avoidable attendance at ED and a key focus on same day emergency care (SDEC) programmes. Other ambitions set out in the guidance include accelerating the restoration of elective care, managing increasing demand on mental health services and working collaboratively across systems to deliver on these priorities. Ambulance trusts have a key role to play in working as part of ICSs to deliver on these ambitions.

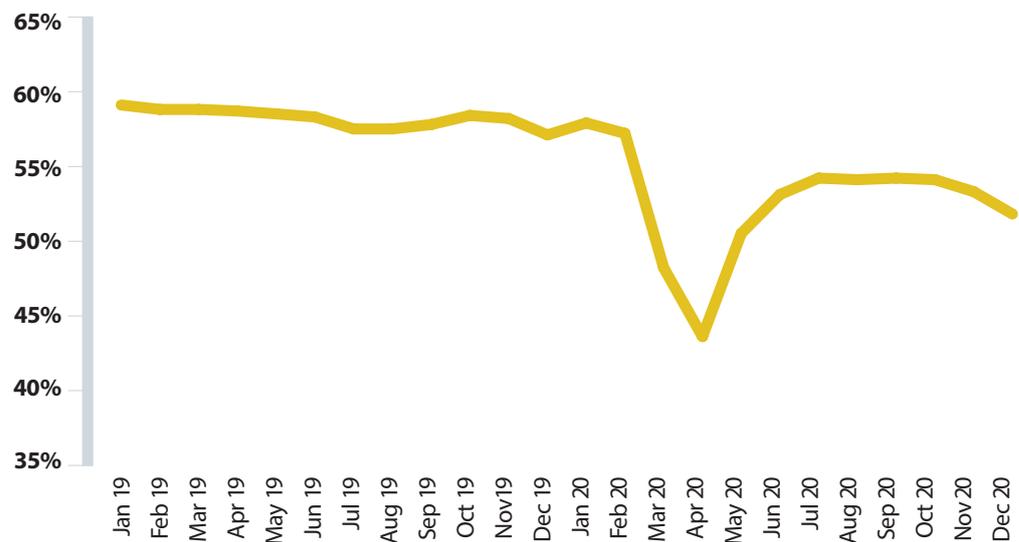
Prior to the pandemic, the long term plan was clear on its ambition to provide patients with the care they need as close to home as possible and reduce pressure on emergency hospital services through reforming how urgent care is organised and delivered. It states, "By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care" (NHS England and NHS Improvement, January 2019). The plan also discussed the use of urgent treatment centres to ensure a consistent model of out-of-hospital urgent care and laid the trail for a comprehensive workforce strategy (the People Plan), noting the need for greater workforce flexibility and coordinated national workforce planning.

How does it work?

As highlighted in the 2018 Carter review of operational productivity and performance in ambulance trusts (NHS England, September 2018), the sector is instrumental in delivering care closer to home and reducing unnecessary pressures on hospitals. Despite increasing demand, ambulance clinicians are taking fewer patients to ED year on year. Ambulance trusts already deploy 'hear and treat' and 'see and treat' response models, navigating patients through appropriate pathways, and signposting others to relevant services, so keeping people out of hospital wherever possible. Ambulance clinicians only convey to ED when there is no other safe option for the patient and when the patient needs comprehensive assessment, treatment in the ED or admission. Greater access to suitable alternative care pathways, available 24/7, could reduce this still further.

In 2019, the proportion of see and treat cases was 29.8%. This increased to 33.9% in 2020. For hear and treat, there were 6.5% in 2019, rising to 8% in 2020. This is a promising trend as it means the proportion of people being kept out of hospital is rising, suggesting that the shift in approach is leading to positive results. This trend is illustrated below, in relation to the proportion of patients being conveyed to EDs between January 2019 and December 2020.

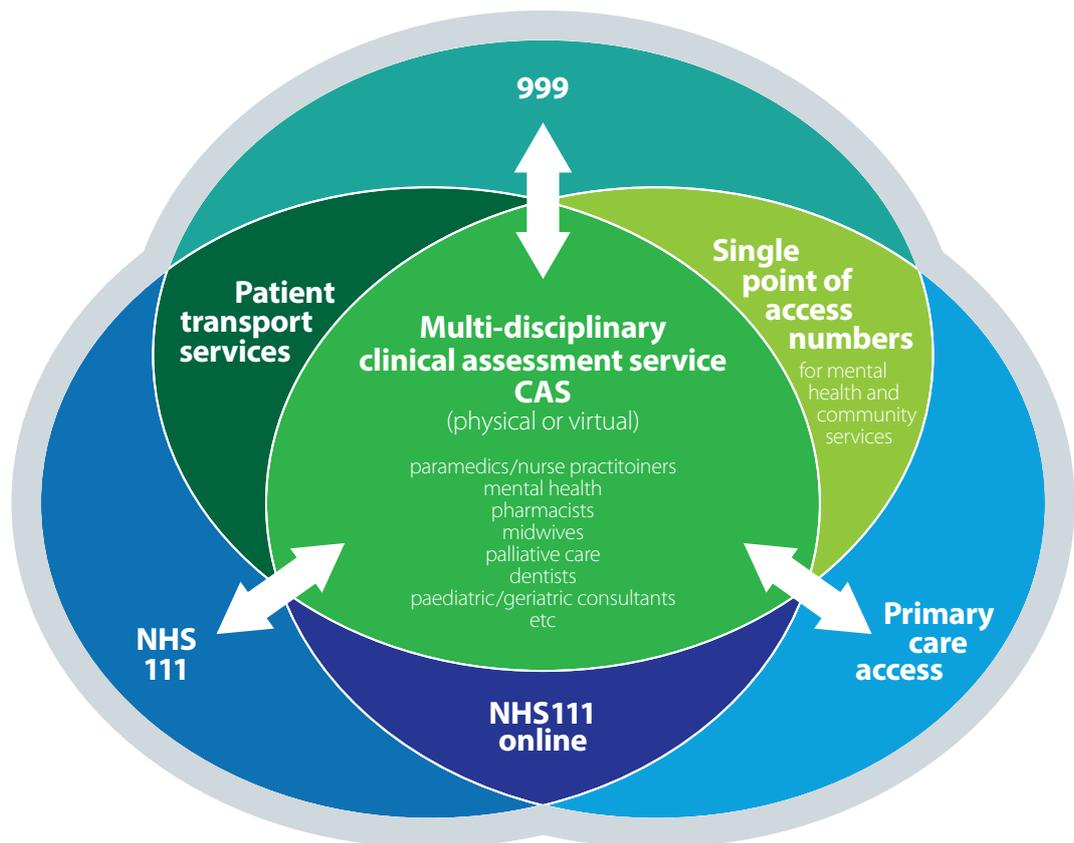
Figure 3
Proportion of patients conveyed to emergency departments



Many ambulance trusts are now working with other providers and commissioners in their region to deliver integrated urgent care services. The multidisciplinary CAS forms a central part of this. The model is designed around having a single point of access for UEC, through which a patient can then access the appropriate service. This means scarce resources are not duplicated in multiple CASs, and patient flow is streamlined, leading to a better patient experience. It also allows for effective strategic commissioning, whereby local needs can be identified and resources matched accordingly, for example ensuring there is additional mental health expertise as part of the CAS in areas of high need. The mental health focus of several trust initiatives is explored further in chapter three of this report and the 111 First model is covered further in chapter four.

It is also important to realise the ambulance sector's full potential to support elective recovery and measures to tackle the care backlog. Non-emergency patient transport services (NEPTS), some of which are provided directly or coordinated by ambulance trusts, support the smooth-running of the healthcare system, ensuring that patients arrive on time for their appointments and that, when being discharged, they can return home quickly. The current PTS market is quite fragmented but the move to system-working provides a significant opportunity for larger system-wide PTS contracting or coordination. This will play a key role in tackling the backlog through efficient use of resources across systems and regions and helping to tackle health inequalities by supporting patients who need help to access the care they need.

Figure 4
Single point of access model

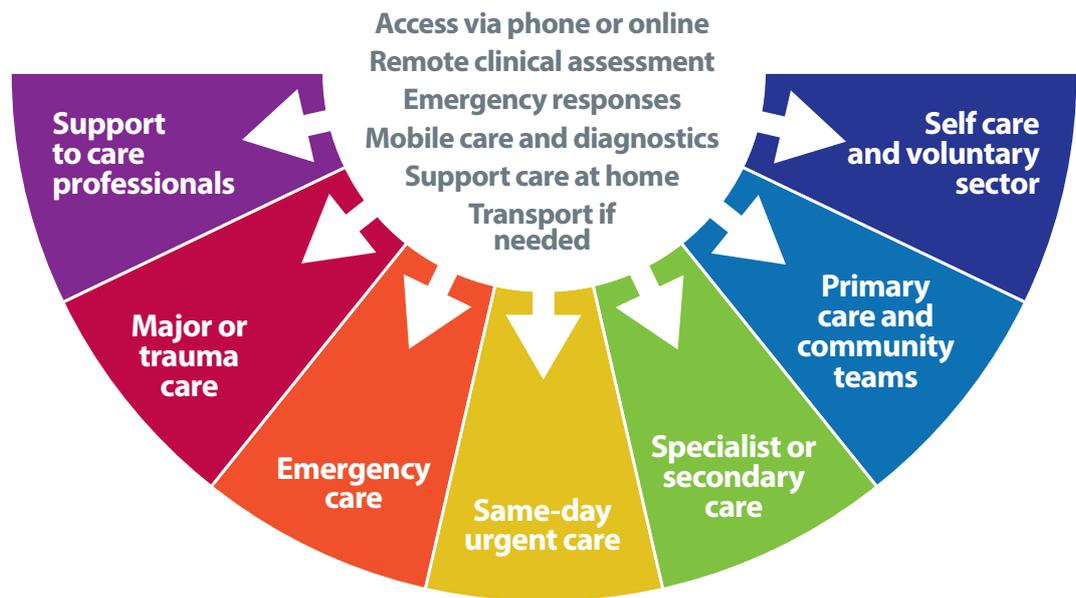


What needs to happen to make this a success?

True collaboration between different types of providers and wider system partners is fundamental to ensuring the integrated model is a success. Ambulance trusts must be involved in regional, ICS and place-level decision making about service design, including defining what single point of access means in practice and over what size footprint. AACE has developed a blueprint model for joined up access to UEC through 999/111 into CAS and onto the appropriate response model or care pathway or local service. By establishing this model on wider footprints, systems can avoid fragmenting services and duplicating use of scarce clinical resources by having multiple access points and CASs within regions. It also creates a resilient and interoperable infrastructure that can make the most of digital innovations and provide clear oversight of how population health needs can best be met.

Figure 5
Right care, first time, every time

To ensure people can get the care they need – right care, first time, every time



It is vital that NHS England and NHS Improvement continues to engage with the sector on evolving ICS guidance to ensure that the guidance reflects the unique nature of the ambulance service and recognises its further potential in supporting system-wide transformation. AACE is currently engaging with NHS England and NHS Improvement and ICS leaders to explore the concept of a single regional commissioning board with oversight for ambulance services working across multiple ICSs. As part of this, there is an opportunity to build on learning from the COVID-19 pandemic in working at scale across regional and ICS footprints.

As explored further in chapter four, we also need digital platforms that are interoperable and allow ready access to patient information, care plans and referral routes between healthcare providers. This model benefits from economies of scale and is already being implemented in a number of areas.

Where is it happening?

CASE STUDY

South Central Ambulance Service NHS Foundation Trust

Provider collaboration to deliver NHS 111 and integrated urgent care service

South Central Ambulance Service NHS Foundation Trust (SCAS) provides integrated urgent care services through collaborative models across Thames Valley, Hampshire and Surrey Heath, covering three ICSs. This case study focuses on the provider partnership in Hampshire and Surrey Heath.

The service's ambition is that anyone contacting the NHS via 999, 111 or online will be offered the right care, at the right time, in the right place in response to their enquiry, needs and circumstances. The aim is to connect callers to the most relevant specialist, either on the telephone or digitally when appropriate, so that neither the patients nor the clinicians have to travel to see each other unless this is necessary for someone's clinical assessment or treatment. When further assessment or treatment is required in a face-to-face setting, the aim is to conclude the telephone assessment with a booked appointment.

Over the years, the partnership model has strengthened and broadened, and there are now a wide range of primary, urgent, emergency, mental health and specialist care partners working together. By leading the collaborative work, through a variety of contractual and partnership arrangements, SCAS is hosting multi-agency teams on a shared technical platform and the public is benefiting from a 24/7 multi-disciplinary CAS.

The benefits of the scheme have included patient access to a virtual CAS via the NHS 111 service, increasing the rates for self-care and reducing the rates for 999 and ED referrals. The new multidisciplinary approach has also brought benefits to staff, who are able to learn from each other in a more diverse clinical team with greater breadth of expertise.

Although the lead-provider contract only started in June 2021, most of the planned developments were fast-tracked during 2020, in order to support the wider system response to the pandemic pressures. This helped to assess more people clinically on the telephone, to resolve enquiries remotely whenever appropriate, and to book people into other services if needed.

Partners are engaging in work to review the assessment and care pathways available in each local care system after people contact the NHS via 999, 111 or online. These reviews involve both providers and commissioners, and provide a foundation for ongoing work to identify any inequities in access, service gaps or scope for further improvement. They also help to share learning and best practice across local care systems.

CASE STUDY

South Central Ambulance Service NHS Foundation Trust

Paramedic on-scene referrals support tool

SCAS identified that there were key areas for improvement in its service, including non-conveyance rates, managing patients out of hospital and improving tools for referral. SCAS recognised that sometimes the wrong patients were being conveyed to hospital and, although there was a clinical requirement for additional investigation and/or intervention, it was clear that the ED was not the right care environment.

Taking a system-wide approach and focusing on same day emergency care (SDEC), a model of care aimed to minimise and remove delays in the emergency patient pathway, the trust has enabled on-scene referral into SDEC and other secondary care services for paramedics and clinical staff. A key aim of this model is that patients receive care in the right place, first time, helping to improve patient flow.

SCAS has utilised a system called 'SCAS Connect', an app-based tool for effective referral, as an enabler for this work. 63% of clinicians now access the system and 69% of patients have received a more appropriate primary or secondary care service referral as a result. The work is ongoing as part of the SCAS urgent care pathway improvement programme with the aim to build up confidence and utilisation of the tool to 100%.

The main criteria for referral is reliant on not only the system to guide paramedics but also the clinical conversation with the service that's being referred to. This supportive measure to encourage referrals allows SCAS clinicians to understand that no decision needs to be made in isolation. To highlight this the team have been utilising the strapline, 'Click before you call; call before you convey'.

The trust has had to navigate a number of challenges with developing this way of working, including the culture shift needed for frontline paramedics in considering different referral routes, ensuring consistent SDEC provision across the region, data extraction, and effective utilisation of the SCAS Connect system. To help overcome these challenges, SCAS acknowledged the best approach was to collaborate and ensure teams felt ownership of the new model.

The benefits of the model have included having more options for paramedics on-scene, including a number of 24/7 services, a continuing downward trend of non-conveyances and enhanced patient experience. In total, 9,422 patients have been directly referred to either medical or surgical SDEC from SCAS paramedics, meaning they have not been conveyed to an ED. This is a huge step in the right direction for improving patient experience, using clinical time effectively and avoiding unheralded demand in ED. SCAS is continuing to expand the model within the region with the aim of ensuring that 100% of patients experience care in the right place, first time.

CASE STUDY

Yorkshire Ambulance Service NHS Trust

Regional coordination of non-emergency patient transport services

Yorkshire Ambulance Service NHS Trust (YAS) is taking on board learning from its role in regionally coordinating NEPTS during the COVID-19 pandemic. National guidance in response to the pandemic meant NHS ambulance trusts were mandated to coordinate and support all regional NEPTS contracts. This was to ensure sufficient oversight and support for patients requiring transport to and from NHS services. It also meant that an accurate assessment of the situation in each region could be established for national decision-makers.

At the start of the pandemic, YAS engaged with transport providers throughout the region, including local authorities, community and voluntary organisations, taxi companies and private ambulance services to coordinate resources. While there were far fewer patients attending outpatient appointments or being taken into hospital for elective procedures, the focus was to support discharge from hospitals to ensure there was sufficient capacity for incoming COVID-19 patients and to continue supporting patients for urgent treatment and diagnostics. YAS provided a single point of access for teams across primary, acute and community care services to escalate PTS needs, including supporting providers, for example around PPE supply and ensuring the right vehicles and mitigations were provided for safe patient journeys. The trust also provided NHS England and NHS Improvement with daily PTS activity data, to ensure oversight of transport capacity and to escalate any regional concerns. As well as developing existing trust volunteers, YAS launched a campaign to recruit more members of the public and now has almost 300 volunteers supporting PTS.

The trust had to navigate challenges in coordinating NEPTS providers, including:

- information sharing
- access to personal protective equipment (PPE) for non-NHS providers
- high staff absences due to COVID-19 related sickness or isolation
- a 40% vehicle capacity reduction due to social distancing, which led to the need for increased funding support from commissioners.

The main benefits of regional coordination were that patient journeys continued in a timely manner, waiting times in hospitals were kept to a minimum and, in turn, the infection risk to patients, staff and members of the public was reduced. By coordinating resources at a regional level, YAS was able to manage capacity fluctuations in other parts of the system. Staff both within YAS and other PTS providers benefitted from increased confidence as a result of being supported in an uncertain environment.

The trust intends to build on the relationships established during the pandemic to respond to the increased demand for planned care and backlog recovery over the coming months. An important part of this relates to tackling health inequalities by ensuring people are able to access healthcare. Ensuring that non-emergency patient transport continues to be part of the conversation with ICSs is just one of the many steps that ambulance trusts can take to help prioritise patients who need healthcare services the most.

Innovative workforce models

Why is this important?

The way in which health care systems – and people – work is changing. The long term plan set out the need for greater workforce flexibility and coordinated national workforce planning, and was followed by the Interim NHS People Plan's focus on expanding the workforce and ensuring adaptivity and a more varied skill mix. The interim plan talked of moving to a model where teams of professionals from different disciplines work together to provide more joined-up care, stating that this multidisciplinary approach "will become the norm in all healthcare settings over the next five years" (NHS England and NHS Improvement, January 2019). This continues to develop, with the **NHS People Plan 2020/21** outlining Health Education England (HEE)'s plans to support local health and care systems to establish the infrastructure for 'generalist schools' with new training opportunities from August 2021.

The need for multidisciplinary approaches to workforce is increasingly clear from the more flexible career paths that NHS staff are choosing, and from the development of ICSs and the resultant increase in cross-organisational working. Ambulance trusts increasingly employ multiple professions across their frontline roles including nurse practitioners and mental health nurses. The pandemic brought about rapid changes to minimise barriers to these approaches, reducing bureaucracy related to staff movement between employing organisations and different clinical settings, and allowing staff to work to the top of their license. The wider implementation of the digital NHS staff passport, for instance, enabled staff to begin new posts more quickly, and avoid repeated (time-consuming) training. Work is being undertaken at national and local levels to determine how beneficial changes such as these can be retained, but there remain other barriers to realising a multidisciplinary, sufficiently staffed, workforce in the longer-term.

The most significant of these is the lack of a long term, fully costed and funded, workforce plan. Before the COVID-19 pandemic, there were almost 2,000 vacancies across the ambulance sector. The vacancy rate varied between regions, with some areas as high as 10.8% and other areas as low as 0.5%. The interim people plan projected the need for an additional 2,500 paramedics by 2023, but no funding was attached to realise this figure. Moreover, the sector has serious concerns that this figure is insufficient to cover anything more than attrition, nor does it take into account the increasing role that paramedics are expected to play within the primary care setting, for example with paramedics now included as additional roles in PCNs.

This concern has grown in the wake of the pandemic, with some **ambulance trust leaders reporting** that staff are leaving their organisations due to burnout, early retirement, or other effects from working in the pandemic. Pressures are being felt by all staff, including those working in emergency operations centres, who are daily facing very visible demand challenges and delayed responses. Retention of staff is arguably a bigger challenge than ever, with recruitment also necessary to meet increasing demand and tackle the care backlog resulting from the pandemic. A fully costed and funded workforce plan is vital to addressing this, but in the interim, ambulance services have been adapting the way they work to begin meeting these challenges.

This includes focusing on areas like increasing mental health expertise within the workforce by bringing in specialist staff. The long term plan made welcome commitments to build the capability of ambulance staff to respond to patients presenting with mental health issues. If adequately resourced, this should help to increase capacity in the system. The necessity of this is clearly shown in figures from 2019, when the London Ambulance Service NHS Trust (LAS) received 168,000 mental health calls and attended over 105,000 incidents caused by mental ill-health – almost 9% of total incidents **attended by the service that year**. People with mental ill health are more likely to use emergency hospital care than those without mental ill health and 46% of people with a mental health condition also have a long-term physical health condition (King's Fund and Centre for Mental Health, February 2012). Given the reciprocal nature of this link, improvements made to mental health provision often improve patients' physical wellbeing, and vice versa.

Mental health expertise within the ambulance workforce is particularly important given that EDs are not always the most appropriate place for people in a mental health crisis. While there has been progress in expanding services within EDs to ensure that people in crisis have access to the specialist care they need, the coverage and quality of these services remain patchy. There are still areas of the country where these specialist teams are not available at all times or for all ages, and now that all trusts are under infection control measures due to COVID-19, beds are more limited and wait times are longer. Adapting response models to avoid unnecessary conveyance to hospital for people with mental ill health is, therefore, an important focus for ambulance trusts, but must come hand in hand with the necessary alternatives to ED being in place. These alternatives could also **reduce pressure on ambulance services**.

There is significant focus on mental wellbeing for staff as well as patients, with funding given to AACE from NHS England and NHS Improvement to progress its **collaborative work on suicide prevention within the sector**. The work, commissioned by the chief allied health professions officer for England, includes research which demonstrates the increased suicide risk for paramedics, and identifies risk factors which are detrimental to mental health and wellbeing more widely. These factors are the foundation for ongoing action in this area.

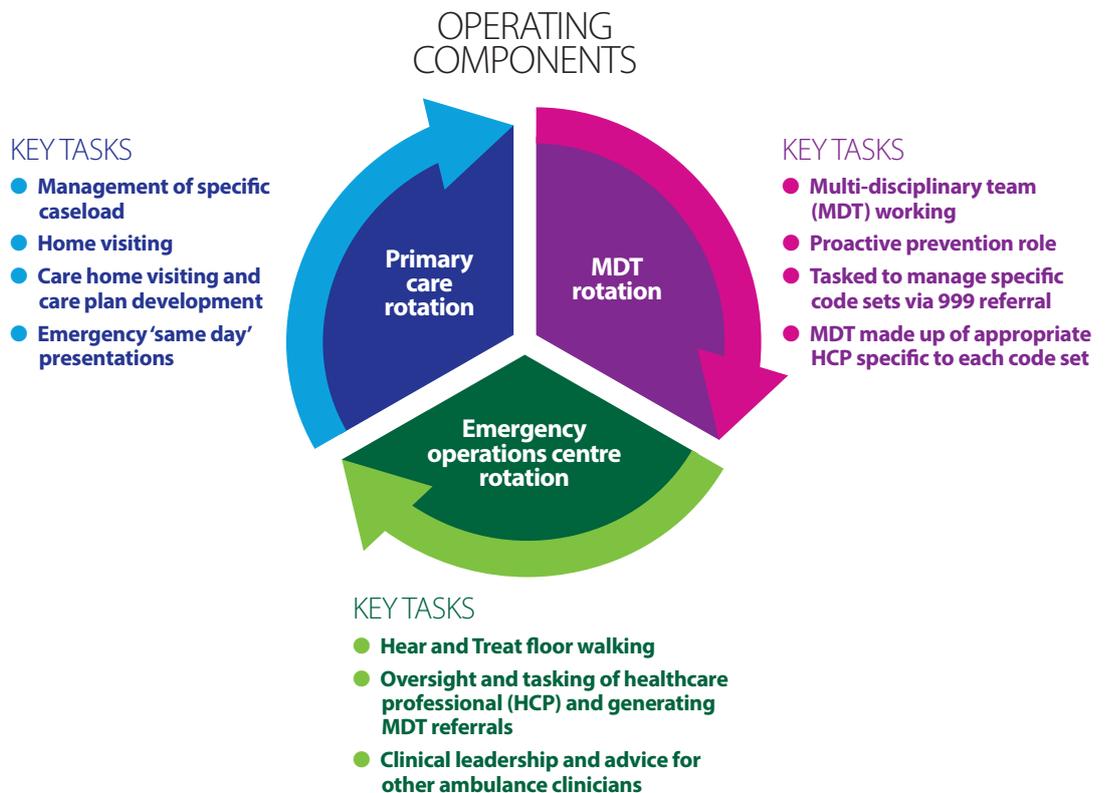
How does it work?

Before the pandemic, trusts were already changing training and working practices so that paramedics can develop and learn alongside other types of healthcare professionals, and therefore be deployed differently. One model of this is rotational working, whereby specialist and advanced paramedic practitioners rotate between clinical settings, using their advanced clinical assessment skills to help provide the right response the first time. This could include working in the clinical hub in an emergency operations centre, or in a CAS providing 'hear and treat care' via telephone consultation, or out with community multidisciplinary teams (MDT), and in primary care. It is particularly notable that this work was already well underway before the pandemic hit, when we saw the NHS flexibly deploying some specialist staff into more general settings during the first peak, as well as a huge increase in telephone and video patient consultations. There have been local initiatives to codify this learning now

that the peaks of the pandemic are behind us, such as one trust's commitment to keep staff who were redeployed and enjoyed the experience involved in one shift per fortnight in their redeployed setting.

The rotational working model used by many ambulance trusts may be a useful blueprint for other providers to use in retaining benefits of increased cross-organisational working from the pandemic. An **evaluation of the model** has shown it is feasible and could have a positive impact on patient experience, workforce retention and reducing hospital conveyance rates. During a pilot in north Wales, just 30% of patients went to ED, while another 33% were managed without any further referral. The added value of this approach is that trained and experienced staff are kept in the workforce while simultaneously supporting GPs and primary care.

Figure 6
HEE's rotational paramedic model



What needs to happen to make this a success?

The rotational model is especially relevant in the context of increased focus on the contribution that paramedics can make to improving capacity and providing appropriate care within primary care settings. Paramedics are now eligible for the PCN Additional Roles Reimbursement Scheme (ARRS), through which they undertake work for a GP practice. Paramedics were added to the ARRS in April this year, but there are outstanding questions regarding how they should be employed, trained, supervised and supported. As such, this poses a number of risks to ambulance workforce capacity and stability and the successful development of the PCN model.

The potential loss of more senior and experienced staff to primary care at a time when ambulance trusts are already understaffed and struggling to recruit to the levels they need is worrying. The service could lose vital mentoring and supervisory capacity, affecting the quality of the whole UEC system given that less experienced paramedics are more inclined to convey patients to ED. Appropriate training must therefore be factored in to equip paramedics with the right skills to manage lower acuity cases in primary care. If appropriately commissioned, the rotational model could also be used to manage this risk effectively, with paramedics continuing to be employed by ambulance trusts which provide the supply to PCNs on a rotational framework. It does not, however, solve the issue of understaffing more broadly. The ambulance sector is committed to working collaboratively with NHS England and NHS Improvement and the PCN network on the next phase of the ARRS roll-out, focusing on lessons learned and monitoring the impact on the ambulance workforce.

Joined-up workforce planning at system and regional level, as well as effective longer-term planning in coordination with the education sector, is essential. We need to see flexible workforce models being supported in the forthcoming updated People Plan (now expected in 2022), alongside a broader understanding across the health sector of the paramedic workforce as a whole – their capabilities and skill sets, and the steps needed to foster equality, diversity and inclusion. This includes ensuring there are sufficient paramedic training places in universities, and supported placements within the UEC system during training, due focus on paramedic retention and ensuring that training and mentoring capacity is created and funded in order to increase the overall size of the paramedic workforce, including for new PCN-supported roles. This has to be undertaken as part of work which is so desperately needed at a national level, for a fully costed and funded workforce plan, based on the practical needs of systems.

To build the capability of ambulance staff to respond to patients presenting with mental health issues, the mental health investment standard (MHIS) has a key commitment to support specific initiatives from ambulance services, for example having mental health nurses in emergency operations centre clinical hubs and CAS. However, there are concerns that money is failing to reach ambulance services due to issues with mental health funding flows, and a wider concern that MHIS may be spread too thinly. In **some cases**, the MHIS is seen as a maximum limit based on affordability, rather than a minimum based on need. These concerns must be resolved before ICSs can clarify the extent of funding that's needed to deliver the long term plan's ambitions in regards to mental health.

Current complex commissioning structures for ambulance services, and the need to link with mental health commissioners to access funding, makes this process more difficult. Coherent guidance is needed as to how ambulance trusts and mental health services should be collaborating in order to make full use of this funding. NHS England and NHS Improvement has developed national commissioning guidance for the mental health ambulance response, which is currently being shared with stakeholders for input before seeking sign off ahead of publication. This must reduce complexity rather than increase it. Capital funding is also crucial for the provision of the right mental health ambulance vehicles, as highlighted in the NHS mental health implementation plan. It will be important for systems to prioritise funding these aspects accordingly, and for funding envelopes to be realistic so that this isn't an impossible ask.

There are additional recruitment challenges due to a national shortage of mental health staff, both in terms of numbers and skill-mix, which must be addressed as part of wider calls for a fully costed and funded multi-year workforce plan. These shortages are further exacerbated by increased demand for mental health expertise in other areas, not only in the health sector (for example, in PCNs and acute trusts) but in other sectors (for example, in the justice system, police force, schools and universities). Demand has increased exponentially since the pandemic began, with cases often more complex and of higher acuity. This increase in demand is expected to continue over the months and likely years ahead, so it is vital to get this right.

Where is it happening?

CASE STUDY

North West Ambulance Service NHS Trust

Community specialty paramedics and new pathways

North West Ambulance Service NHS Trust (NWAS) responded to the national policy direction for integrated UEC being delivered closer to home by developing its team of community specialist paramedics alongside senior clinicians.

These staff members work with external providers to establish and manage community pathways. The pathways are responsive to the health needs of the specific communities they serve and include mental health, respiratory, falls, frailty and – during the COVID-19 pandemic – a focus on social isolation and supporting those struggling to cope with everyday life.

NWAS developed social prescribing referral pathways in partnership with primary care networks and voluntary, community and social enterprise providers. By referring patients to these pathways, clinicians are able to support those patients who, following assessment, have been identified as having low acuity health needs or long-term conditions that need further management by primary care. These patients may struggle with anxiety, loneliness

and a lack of support with daily living. Social prescribing practitioners can then work with people to link them to support in their local communities.

One recent patient is Jean, a 71 year old female who lives alone. Recently discharged from hospital following a fall, she had called 999 as she felt unwell. An ambulance crew arrived and, following a medical assessment, were able to establish that she did not have an urgent health care need. However, the crew realised that Jean was struggling with loneliness and to manage her everyday living. With her permission, she was referred to a social prescribing pathway managed by Age UK. Following her referral, she now has support with food shopping, referrals to the local continence and mental health services and to a local befriending service. This proactive, multi-agency, preventative approach is supporting Jean to stay well and should reduce her need to call for emergency support in the future.

NWAS currently has 10 social prescribing pathways in place with more in development. They are exploring how social prescribing pathways could be extended to NHS 111, and used to support high intensity service users. In extending the range of pathway providers to include voluntary, community and social enterprise partners, the care of patients is further promoted within their local community, reducing the pressure on emergency hospital services.

This innovative approach is supported by a dedicated group of community specialist paramedics and advanced paramedics working across the trust.

CASE STUDY

South East Coast Ambulance Service NHS Foundation Trust **Mental health professionals in emergency operations centres**

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has introduced mental health professionals into its emergency operations centres to provide expertise on first contact with the service following pathways triage. The initiative, which has formed part of SECAmb's CAS since October 2020, allows the service to ensure that patients presenting with mental health problems have immediate access to mental health expertise from clinicians who are linked into mental health provider trust clinical systems. This means advice and support can be provided to frontline crews on scene, and the need for ambulance attendance and conveyance to EDs is reduced where appropriate.

This initiative has been developed simultaneously with plans to join with two mental health provider trusts in Kent and Sussex to co-locate their single point of access teams in SECAmb's emergency operations centres to work in partnership with SECAmb's mental health professionals. The service now provides 24/7 cover.

Benefits for patients include having initial contact with a mental health professional, being provided with immediate advice and support with appropriate signposting and having contact with a professional who has defined links with the local mental health provider trusts, linking in with emerging alternatives to emergency departments (for example, safe

havens). In the longer-term, benefits are expected to include reduced ED conveyance (where it is not appropriate), increased capacity for frontline crews, and joint working opportunities with local mental health provider organisations.

CASE STUDY

London Ambulance Service NHS Trust

Advanced paramedic practitioners in urgent care

LAS has invested in specialist and advanced paramedic practitioners (APPs) for urgent care, who have undergone extended training in assessing and treating people with medical emergencies. This is a key factor in safely reducing ED conveyance, alongside providing meaningful clinical development opportunities for experienced paramedics increasingly in demand within other areas of the health service. This work aligns to NHS England and NHS Improvement's *Transforming Urgent and Emergency Care Services in England*, and the 2018 *NICE guideline on emergency and acute medical care in over 16s*.

HEE funded an initial pilot (and gave subsequent top up funding), and higher education, primary, and urgent care providers work as partners with LAS to support education and training for the initiative. The initial pilot comprised of a small group of trainee APPs in urgent care, who received additional postgraduate education. The trainees worked rotationally within the emergency operations centre and clinical placement settings, as well as the 999 operational environment.

The initial pilot was successful, resulting in an extension of the trial period and recruitment of additional staff. Further evaluation showed that the service was safe and effective, providing lower rates of conveyance compared with a 'business as usual' response accompanied by a lower re-contact rate. The trust found targeted dispatch of APPs in urgent care challenging initially, but overcame this by adding a team member within the emergency operations centre.

Funding was necessary to the pilot's success, in order to procure additional equipment. Initial hurdles in the training programme were overcome collaboratively, with robust assessment and selection methods for recruitment, and by ensuring alignment with the College of Paramedics recommendations and HEE advanced practice definitions.

The service now benefits patients hugely, enabling them to receive care closer to home when accessing the 999 system, and avoiding adverse outcomes associated with unnecessary hospital admission. Ambulance service capability to assess and manage urgent care presentations safely in the community has increased, and is evidenced by low re-contact rates.

Staff are also benefitting from a clear clinical career progression pathway, complementing other pathways in areas such as operational management. The programme enables staff to remain in a clinical role, enhance their career opportunities, and provide more

comprehensive care. The APP urgent care programme also avoids dispatch of a dual-staffed ambulance with the associated costs in favour of a single responder less likely to convey the patient to hospital. This has resulted in job cycle times being lower overall, and ambulances are available to respond to other calls.

Further upscaling of the service has the potential to further reduce unnecessary conveyance, reducing pressure on EDs and reducing ambulance handover delays. APPs working in the emergency operations centre are also able to perform additional roles, such as providing telephone advice to patients. The service is now due to expand, with the addition of further trainee APPs to improve consistency and times of operational cover across the trust, and is replicable across all ambulance trusts given the appropriate support, level of education, and system-wide buy in.

Digital transformation

Why is this important?

Digital transformation remains a key enabler to service improvement. New digital ways of working can improve clinical outcomes, patient safety, the user experience of both patients and staff, and staff engagement more broadly. What is more, successful transformation can yield financial efficiencies, either through directly releasing savings, or the avoidance of 'failure demand' – that is, the cost created by poorly designed services that create pressures elsewhere in the system. Digital transformation, and the more effective use of data, also underpins the integration agenda. For ambulance trusts covering several ICSs and working with every part of the health and care sector, the gains will be significant: better service coordination and population health management, a reduction in avoidable waits and better response times.

The ambulance sector has traditionally been at the forefront of digital developments. Long before the pandemic, service delivery often involved remote care, with ambulance staff equipped with the digital skills and technology to carry out their jobs. This has been acknowledged in the Carter review, which noted that the adoption of new digital technologies has been a key driver for reducing conveyance rates to hospitals (NHS England, September 2018). The experience of the ambulance sector's three global digital exemplars also demonstrates the progress made by ambulance trusts which have put digital innovation at the core of their services. Indeed, the nature of ambulance services has led to innovations that other organisations have since adopted, such as using digital technologies to connect staff with the relevant expertise, advice and guidance.

The response to COVID-19 has accelerated these digital ways of working. Better sharing of medical records between ambulance trusts and other health and care organisations has improved and quickened clinical decision making. Collaboration between ambulance services and secondary care providers enabled paramedics to provide care to COVID-19 patients remotely, reducing unnecessary admissions and virus transmissions. New innovative ways of working, such as 111 First, were rolled out nationally and supported by cloud-based digital software to ensure seamless clinical handover for patients who needed to visit ED.

How does it work?

The nature of ambulance service provision – 24/7 care that is delivered as a responsive, connected service – has meant that many ambulance trusts have long placed digital at the heart of their long-term strategies. The sector has often been best placed in terms of interoperability, telemedicine and emergency patient flow.

The global digital exemplar (GDE) programme has been instrumental in driving some of these initiatives, examples of which include establishing live-link video capability with care homes, automating cumbersome processes related to ambulance dispatch, developing a simulator to be able to model impacts of planned system changes, and streamlining the way ambulance systems digitally pass patient information to hospital and urgent care systems. The digital aspirants programme is looking to build on some of these successes although

many ambulance trusts will now be seeking to work more closely with their ICS partners to drive local innovations.

The pandemic accelerated much of what was already underway in the sector: closer working between ambulance and other health and care partners, a streamlining of priorities and empowering of frontline teams to get on and deliver innovations. As the sector looks to support broader NHS recovery efforts, trusts continue to stress the importance of digital transformation as an enabler rather an end in itself. Digital is becoming more integrated into wider corporate strategies and ambulance trusts are looking to invest in people and skills, as well as digital technologies. Because of this, digital is no longer seen as the preserve of the IT department – it is now everyone’s business.

What needs to happen?

Building on the progress made during COVID-19 will require greater access to both capital and revenue funding. As highlighted in NHS Providers’ report, *Rebuilding our NHS: why it’s time to invest*, a survey of trust leaders revealed the most commonly cited capital priority or opportunity was investment in digital and IT (67%). In the ambulance sector, a better capital settlement could enable trusts to invest in digital transformation to improve resilience and responsiveness, for example through streamlined and interoperable computer aided dispatch systems, telephony and triage tools. Such systems represent an investment of many millions of pounds not afforded to some trusts in recent years. This needs to change if the ambulance sector is to be truly “digital first” by 2029, as set out in the long term plan.

Revenue funding is also needed as digital solutions increasingly move to a blended funding model (including software as a service arrangement). Upfront digital investment now needs to be matched with an ongoing revenue commitment to pay for IT developers, software licensing and the training/educational needs of existing staff. Ambulance trusts now looking to adopt cloud-first strategies must also move away from on-premises data centres, which will represent an additional revenue commitment. So while capital funding is important, ambulance trusts must also have access to sufficient revenue funding to maximise its digital investments.

Some ambulance trusts continue to face a significant challenge in managing legacy IT systems, with infrastructure out of support or out of contract. These systems represent a cyber security risk but also impact patient care with slow sign-ins and IT outages. Addressing these IT backlogs will require significant resources and time, and benefits realisation, at least in the short term, will be difficult. Trusts need this foundational infrastructure in place before they can consider more advanced digital transformations, such as automation or AI.

National funding arrangements available for ambulance services could be more transparent and consistent. For example, while there were three ambulance GDEs, so far only one ambulance trust has been announced as part of NHSX’s digital aspirant programme. Ambulance trusts have fed back that the bidding process for some national schemes can be cumbersome and overly bureaucratic.

It's also clear a one size fits all approach doesn't work for national funding, with variation in terms of capabilities, broader digital maturity, financial sustainability and variation in service delivery. At a system level, ambulance trusts face an even more complex environment, having to agree digital priorities and sign up to transformation plans across several ICSs.

It is positive that a new ambulance data set is in development, with the aim of providing an improved, consistent level of detail about how ambulance services respond to and treat the thousands of calls that are received every day. The new data set will be particularly important in understanding how and why people access UEC, which should help to reduce pressure in the system, support the tackling of health inequalities and improve patient outcomes, safety and experience. An important part of the initiative will be ensuring better linkage to other resources, such as the emergency care data set, in order to understand the patient outcomes associated with ambulance service interventions.

Where is it happening?

CASE STUDY

Yorkshire Ambulance Service NHS Trust

Frailty response line

During the pandemic, the Hull and East Riding frailty response line was set up by the YAS to provide ambulance clinicians, along with primary and community care staff, with support, access, and information to:

- reduce unnecessary admissions to A&E for frail patients living at home or in a care home
- provide the right treatment, in the right place based on patient choice
- aid clinical decision making to improve care decisions.

A team of geriatricians, GPs and advanced nursing practitioners run the careline seven days a week, twelve hours a day. More than 1,300 patients were supported during the first wave of COVID-19. This service has been important during the pandemic as it prevented suspected COVID-19 patients from entering acute settings.

YAS saw their conveyance rates for patient attended by a paramedic to its lowest ever level, and there has been an overall reduction in A&E attendances and emergency admissions to the local acute trust. Patients now receive care in the right place, at the right time, with direct access to specialist support and the development of patient centred care and treatment plans.

CASE STUDY

West Midlands Ambulance Service University NHS Foundation Trust

Right place, first time: direct referral to frailty SDEC

Older and frail patients account for 5-10% of all those attending EDs, and 30% in acute medical units. During the pandemic, older and frail patients remained a high portion of those conveyed by ambulance, but had increased anxiety around attending hospitals due to fears of catching COVID-19.

The South Warwickshire NHS Foundation Trust (SWFT) knew that there were missed opportunities for providing care closer to home for these patients, so decided to redesign the available clinical pathway. This redesign gave paramedics access to advice, and direct referrals to the frailty SDEC. This enabled patients to access the right care first time, without conveyance to ED.

The model has now been enhanced and embedded with the provision of direct phone access to the multi-professional frailty team. This enables paramedics to assess older and frail patients more effectively, increasing their ability to support patients at home or to convey them directly to the right place for care. By reducing unnecessary steps, wait times are reduced, and patient can be supported on a SDEC pathway where appropriate.

The SWFT frailty team is cross-workforce – geriatricians, nurses, and therapists, who all worked together to embed this learning to redesign the pathways in the West Midlands Ambulance Service University NHS Foundation Trust (WMAS) more widely. WMAS paramedics can now access the frailty team through 'consultant connect', a service funded by the clinical commissioning group (CCG) to provide direct remote access to advice and guidance from geriatricians. Giving access to the live electronic patient record within the ambulance service to all relevant staff means that paramedic assessments can be viewed by the geriatricians on consultant connect. This has led to more informed decisions about care, made in partnership with the patient, carers and the frailty team.

WMAS' work in this area has produced positive benefits for patients, staff, and the system, with an increase in patients treated as SDEC (with 'zero-day length of stay'), and a decrease in the average length of patient stay from 14 to 4.5 days, whilst sustaining a 95% ED performance.

CASE STUDY

Spotlight on NHS 111 First

All ambulance trusts providing NHS 111 now provide the 111 First option. Below are some examples of how this is working.

South Central Ambulance Service NHS Foundation Trust

The beginning of the pandemic saw more people arriving in ED, placing a significant strain on services and also increasing the risk of COVID-19 transmissions. South Central Ambulance Service (SCAS) collaborated with Portsmouth Hospitals University NHS Trust to develop a new 111 First pilot system, giving patients the ability to book directly into the ED via 111.

The scheme has established a new GP-led CAS and introduced a new electronic appointment booking service. Patients are clinically validated, with those who need it given a slot to attend ED while others are directed to more appropriate and suitable care. SCAS supported a rollout of their patient management software, Aداstra, within the acute setting to ensure seamless handover of patients.

With the pilot a success, 111 First was rolled out nationally over winter. Feedback from patients has been positive, and to date nearly 43,000 appointments have been made using the SCAS 111 First Service, avoiding the need for patients to wait in crowded ED rooms.

West Midlands Ambulance Service University NHS Foundation Trust

Anticipating an increase in 111 calls due to the 111 First model, WMAS put several services in place to support patient flow and access to care:

- **ED direct booking**, which supports acute trusts in managing patient flow during periods of increased activity. Direct booking encourages patients to call 111 before taking themselves to an ED, meaning that more patients can be referred to other services or given home management advice, as appropriate. WMAS' service allows for timed appointment slots to be booked, whilst sending the patient's electronic record to all West Midlands EDs, speeding up access to care.
- **Clinical validation** for category three and four incidents, as well as emergency treatment centre (ETC) incidents. Whilst this places more initial demand on clinicians, it has resulted in much smoother patient flows. In June 2021, 86.77% of category three and four incidents received clinical validation, with 54.5% of patients receiving a different outcome, significantly reducing demand on emergency resources. In the same month, 34.11% of ETC incidents received clinical validation, resulting in 9.53% of patients triaged through 111 being referred to an ED.
- **Video consultation** software to support clinicians to provide enhanced face-to-face clinical triage. While this is dependent on the patients' ability to access and use appropriate technology, a pilot trialling the 'AccurRX' software has been completed, and provided proof of concept. WMAS now has video consultation capability for all clinicians across the IUEC, covering both 111 and 999 functions. Staff feedback, monitored with short post-assessment surveys, has so far shown positive responses from all clinicians.

London Ambulance Service NHS Trust

LAS has implemented a 111/999 and Barts Emergency Access Coordination Hub (BEACH) integration programme. This helps to coordinate access for patients requiring secondary UEC.

BEACH helps to coordinate secondary UEC for patients who do not require immediate conveyance or referral to ED, providing a greater range of alternative pathway options – this may include remote clinical assessments and arranging appointments, or referral to an out of hospital team including a community emergency medicine resource. This enables patients to access care before attending an ED via conveyance from 999 or referral from 111. As of May 2021, 27% of 111 patient referrals to BEACH were managed without requiring attendance at ED. The implementation of this collaborative project has improved ED flow and wait times, and the project is now assessing any unintended impact for 'on scene time' with ambulance crews and whether patients could have been referred to alternative pathways directly by LAS clinicians.

Key asks of government and the national NHS bodies

5

As the case studies in this report show, the ambulance sector is contributing substantially across a number of ICSs towards delivery of key NHS priorities in transforming care navigation and ensuring people are treated in the right place at the right time. We have focused on its role in driving integrated care from the access points, deploying innovative workforce models and transforming services using digital approaches. This is important both for the continued implementation of the long term plan and the task of recovering care backlogs as we move through the next phase of the COVID-19 pandemic.

This is all within the context of rising demand for services and additional workforce pressures. With appropriate support, recognition and investment, there is potential for the sector to do even more.

AACE and NHS Providers are therefore calling for:

Policy alignment, ensuring the voice of the ambulance sector is involved in strategic planning and decision-making at national, regional, ICS and place level.

This includes:

- continued meaningful engagement with the ambulance sector at national and regional levels on evolving ICS guidance and moving ICSs to statutory organisations, joined-up workforce planning, population health management, service design and commissioning
- wider promotion of the rotational paramedic model, in a measured way, as part of the ongoing reform of the GP contract to support the development of PCNs
- the involvement of the ambulance sector in policy developments for primary care and social care which will impact the urgent and emergency pathway.

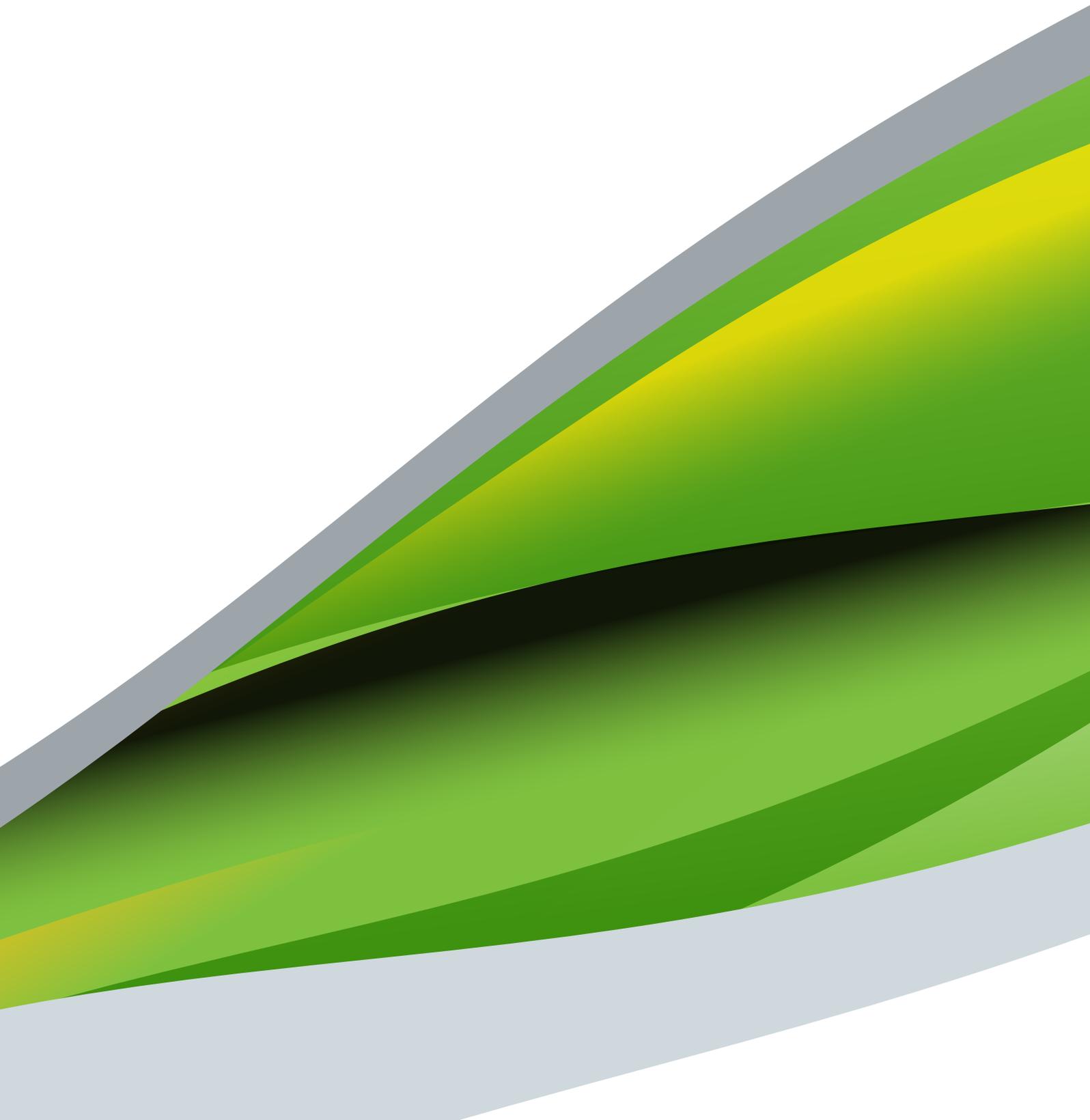
Greater recognition of the ambulance sector's role as providers of UEC, with many care episodes being concluded, either on-scene or over the phone, without the need for onward referral, and as care navigators, ensuring people are treated in the right place at the right time. This includes:

- recognition from national and local delivery partners that the ambulance service can play a more significant role in integration of UEC provision across larger footprints, bringing the benefits of economies of scale and prudent use of scarce workforce resources, whilst supporting local, place-based care and working closely with a wide range of partners including primary care, social care, the voluntary sector and other trusts
- acknowledging that, through working with multiple ICSs, ambulance trusts will have a unique insight into health inequalities across regions and the impact of potential reconfigurations in services, and the best practice approaches that could be scaled up
- specific recognition of the important contribution of the paramedic workforce and the need for flexible workforce models in the next iteration of the people plan.

Whole system investment to build on learning from the pandemic, to match the ambition set out in the long term plan, and to address historic underfunding, in the form of:

- dedicated mental health funding from government, the national bodies and via ICSs, as part of the MHIS, reaching the services that need it most
- a long term, fully costed and funded, workforce plan in the next CSR that takes into account the needs of the ambulance sector
- a multi-year NHS capital settlement in the CSR, in line with NHS Providers' #RebuildOurNHS campaign asks, to unlock capital investment to support further digital transformation and specific fleet requirements (for example, to support mental health initiatives) in the ambulance sector.

With these measures in place, the ambulance sector's role in COVID recovery and delivering the long term plan can be developed to its full potential, to the benefit of the whole health and care system and the patients it serves.





ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

The **Association of Ambulance Chief Executives** (AACE) is a UK-wide membership organisation providing NHS ambulance services with a central body that supports, coordinates and implements nationally agreed policy. It also is a key contact for national bodies including the Department of Health, NHS England, NHS Improvement, Care Quality Commission and Health Education England, and provides the general public and other stakeholders with an access point for information about NHS ambulance services. The AACE works closely with NHS Providers to represent the voice of the ambulance sector within health and social care. The primary focus of the AACE is the ongoing development of the role of ambulance services, working alongside partner providers, in improving patient care. More information about the AACE is available at www.aace.org.uk



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 voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

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