Discussion paper **November 2015**

Developing an ambulance commissioning strategy: Five Year Forward View and beyond

National Ambulance Commissioners Network

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With this paper, we aim to progress the debate, through setting out how ambulance services work within the current system, what as commissioners we believe the future should look like, and the challenges that need to be overcome for this to happen. We hope that its content will inspire further discussion with all colleagues across the healthcare system involved with the ambulance service and support us to move swiftly in providing the public with a modern, fit-for-purpose service that delivers high-quality care.

NHS Clinical Commissioners
The independent collective voice of clinical commissioning groups

Introduction

As is the case with many parts of the NHS, the current way in which ambulance services are provided was not designed to meet the needs of today's population. Changes need to be made to the system to ensure that it remains sustainable going forward while giving patients the best care. These changes need to be made at pace. The recent publication of the Urgent and Emergency Care Review (UEC Review) has provided us with a real opportunity to seize the moment and reform the ambulance service – we must not lose this impetus.

With this paper, we aim to progress the debate, through setting out how ambulance services work within the current system, what as commissioners we believe the future should look like, and the challenges that need to be overcome for this to happen. These challenges include the triage system, ambulance staff's ability to make referrals to community and primary care, the response model and the transport model. We also set out some of the aspects that will enable us to transform the system, which include further developments to the workforce, improved IT and a different payment mechanism. We further consider when it is appropriate for commissioning to take place at a national rather than local level.

The National Ambulance Commissioners Network (NACN), which is part of NHS Clinical Commissioners, represents ambulance commissioners working across all ambulance provider trusts in England. We work with stakeholders on national policy, provoke discussion on key issues where change is needed to deliver better care for patients, and provide a forum for learning and sharing best practice.

We believe in working collaboratively and have consulted with partners across the system when working on this paper. We hope that its content will inspire further discussion with all colleagues across the healthcare system involved with the ambulance service, and support us to move swiftly in providing the public with a modern, fit-for-purpose service that delivers high-quality care.

Key recommendations in this report

- The ambulance service should develop into a mobile health provider working in multidisciplinary teams.
- There should be a refocus on commissioning and provider systems that support non-conveyance and provision of the right care closer to home as its principal aim for most patients, while continuing to provide immediate transport and treatment solutions for those emergency patients who need a fast response.
- We support a shift away from time-based targets for the majority of responses, to ones focused around patient and clinician experience and patient outcomes building on the current ambulance quality indicators (AQIs).
- We need a focus on an improved triage that will be consistent, systematic and focused on the right response for the patient (based on patient outcomes and appropriate speed of response).
- We should increase communication and engagement with the public to provide more clarity around expectations, and how we can shift to providing the 'right' response for them as a mobile treatment service and not simply a speed of response service.
- There is a need to develop a workforce and training plan with commissioners to support the shift to new models of care which are realistic in terms of timescales for implementation and address geographical differences.
- We support and recognise that some ambulance service provision should be commissioned at a national level, particularly with regard to specialist functions covered by the Emergency Preparedness Response and Recovery (EPRR) core standards, for example, the Hazardous Area Response Team (HART).
- Collaboration is fundamental in developing new models of care through a multiplicity of collaborative forms including sub-contracting, alliance and prime providers.

The current context of ambulance commissioning in England

The Five Year Forward View (2014) sets out the need for transformation across healthcare over the next five years and beyond. The need for change comes at a time of unprecedented financial pressures and demands for our health, social care, and wider services that support people's wellbeing. The Office for National Statistics projects that the overall population will grow by about 3 million between 2012 and 2020, with the greatest growth expected in the number of people aged 85 or older. The response to this population growth will need to include recognition, mobilisation and utilisation of individuals and community assets, with health at the heart of local integrated planning and services.

A significant element of the *Five Year Forward View* (5YFV) is around care being delivered locally, but with some services in specialist centres. Both of these ambitions have an impact on an ambulance trust whose organisational form is to deliver care across a large geographical area.

There are 11 ambulance trusts in England and while clinical commissioning groups (CCGs) are responsible for commissioning their services, the commissioning arrangements are based on a collaborative commissioning model.

Ambulance commissioners and providers acknowledge that the current model of ambulance service provision and commissioning is out of date. Like the rest of the NHS, the current service model was not designed to meet the needs of today's population. Health and care systems cannot afford the continued year-on-year increases in activity, and so the way the service is provided and commissioned needs to change. This is not only to achieve sustainability going forward but also to allow patients to enjoy strong experiences and outcomes. We must ensure that the sickest are reached fast, and that everyone receives the right care, in the right place at the right time.

The NACN has many good existing examples of commissioners and providers working collaboratively together, to develop and implement schemes that support care closer to home and avoid conveyance to the emergency department and admission to hospital where it is not required. Schemes such as Primary Care Access, Paramedic Pathfinder, Mental Health Car, to name a few, have all supported ambulance trusts to increase their rates of 'Hear and Treat' and 'See and Treat' (see page 11 for glossary), and reduce the number of patients conveyed unnecessarily. Detailed information for these schemes can be found in our *Good practice in ambulance commissioning* briefing available at **www.nhscc.org**

These successful incremental changes have resulted in some variation across the country. Variation as a result of services being developed to meet local need is a positive change, but variation in patient outcomes needs to be addressed. Conveyance rates do differ and we are not entirely clear why. It could be due to patient demographics and area geography, but evidence is needed to assure ourselves of this. The University of Sheffield is currently undertaking a research project, *Variation in ambulance non-conveyance*, which will provide the empirical evidence to identify some of the factors involved.

This paper provides the ambulance commissioner perspective and considers the balance between the national commitments the ambulance provider is required to deliver against the ambition to develop local solutions for local people. This includes the development of outcome measures that might be considered to support the evaluation of service changes.

It also sets out why the NACN believe that the current ambulance trusts are an integral part of the future urgent and emergency health care system, with further opportunities for them through the emerging new models of care.

These opportunities are set against a backdrop of significant recruitment challenges and the need to review the current training programme to ensure that the workforce is flexible, has the right skills to deliver increased out-of-hospital care, and forms part of a wider multidisciplinary approach.

Key summary

- The current model of provision and commissioning of ambulance services must be modernised to achieve sustainability going forward and to ensure that patients receive the best possible care.
- We should ensure that commissioners and providers alike are committed to the principle that the sickest are reached fast, and all receive the right care, in the right place, by the right resource at the right time.
- The workforce needs further development to assist staff in working across new settings and enable them to treat a wide range of patients across both urgent and emergency care.

New models of care

There have been several reports and guidance documents published over recent years, advocating fundamental change to the way health and care services are delivered.

The 5YFV sets out a clear direction for the NHS, outlining why change is needed and what it will look like, with a focus on new care models designed to deliver improved and increased care locally.

Perhaps more significantly for the ambulance trusts is the work taking place in relation to the UEC Review, led by NHS England, which started working with stakeholders from across the urgent and emergency care system in November 2013. The UEC Review set out its vision for a future system that is safer, sustainable and capable of delivering care closer to home, helping to avoid journeys to (or stays in) hospital unless clinically appropriate.

Moving towards a new model of care for the urgent and emergency ambulance service presents several challenges, which are explored later in this document. The 5YFV sets out how the traditional divide between primary care, community services and hospitals is increasingly becoming a barrier to coordinated health services. It shows the need to start managing systems, networks of care, not just organisations. There is history of managing care across systems with the development of trauma networks, cardiac networks and stroke care. This is the ideal solution from a clinical perspective providing improved clinical outcomes for patients, but there is an impact on the ambulance provider, due to its widening urgent care remit, emergency care remit and transport function.

The new models of care have the potential to involve the ambulance provider, though the outline of the work from the first wave vanguard sites; enhanced health in care homes; multispecialty community providers; and primary and acute care systems, shows that only five areas mention the ambulance trust in the description of their plans. More recently has been the identification of vanguard sites relating to urgent and emergency care to support delivery of the key objectives identified through the UEC Review, which have provided the opportunity for the ambulance service to be engaged in shaping future service provision.

A key element of the future is that there is a multiplicity of urgent care providers, predicated on local need, which ambulance services are able to refer to. These developments will be overseen by urgent care networks and strategic resilience groups, with ambulance commissioners playing a key role to support a system-wide view and reduce conflicts of interest across individual CCGs.

There are a number of elements to the development of the new models of care in relation to urgent and emergency care that will involve and impact on both the ambulance provider and the response model required to support delivery. The 5YFV describes making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies. It identifies that the staff working within ambulance providers will require improved access to a range of clinical advice; access to a shared electronic summary care record; they will need to be empowered to make more decisions to enable the staff to treat patients appropriately or to be able to make referrals in a more flexible way. This could be further enhanced by the development of an integrated clinical hub encompassing a multidisciplinary approach.

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Ambulance providers are also utilising decision tools to support care more locally and to reduce conveyance to hospitals through the use of Paramedic Pathfinder. This requires the ambulance trust and local commissioners to work together to identify gaps in service provision and up-to-date information regarding how to access a service.

Opportunities exist within the proposed new models of care for the ambulance providers to be part of the system solution, but there will be a need for ambulance leaders to look outside their normal boundaries and ways of working to ensure their contributions are recognised and they are seen as one of the system leaders.

The NACN looks forward to the publications from NHS England regarding the planning guidance setting out the expectations of commissioners and providers in relation to: developing ambulance services, workforce development, redesign of payment to support a coordinated system, and the new outcome measures and metrics to understand how the system is performing and how these will influence an appropriate response model.

Key summary

- The ambulance provider is an integral component of a modernised health and care system.
- The vision for the future is of a system that is safe, sustainable and capable of delivering care closer to home, helping to avoid journeys to hospital unless clinically appropriate.
- The impact on the ambulance provider in the development of new systems of care must be considered.
- Ambulance staff need to be trained and empowered to support decision-making to enable patients to be treated appropriately out of hospital or to make referrals in a flexible way.
- Ambulance providers and local commissioners need to work together to ensure there is access to up-to-date information regarding how to access alternative services.
- The system should be built around patients and care closer to home, which is a sea change from the systems being based around the 'acute' trust model.

What could the future look like?

Taking into consideration the future direction of travel for healthcare and the challenges that the system faces, the NACN see the following possibilities for ambulance service provision:

1 Service targets based on patient outcomes building on the current AQIs and patient experience data with a reduced focus on time-based targets other than for the most critical patients requiring such a response.

2 Shift of service model built around appropriate non-conveyance, rather than the current transport model of conveyance, through the further development of the ambulance service as a mobile treatment provider.

3 Adoption of models of provision fit for purpose for rural as well as urban areas rather than a one-model-of-fit service, building on the work already commenced across many rural areas.

4 A diversification of ambulance provision into multidisciplinary working in situ as well as mobile response units.

5 The further development of an 'enhanced PTS/intermediate tier' response service at pace to provide more flexible responses that aid appropriate conveyance and make the most efficient use of '999' resources.

6 Focus on clinical triage to be consistent on a national basis and provide the 'right' response every time through clinical hub development.

7 A workforce and training plan which supports the shift to new models of care and is realistic in terms of timescales for implementation and addresses geographical differences.

8 A payment system that supports the shift of fixed and semi-fixed costs as well as variable costs from the secondary sector to community and primary care over a period of transition.

In order to realise these ambitions for the future there will need to be a change in the way that the systems work, and we will need to be provided with the tools to enable change to happen at pace. We will consider these in the following sections of the paper, setting out how we believe that the challenges should be resolved and where further discussion and collaboration is necessary.

What changes are needed to the way the system works?

Some key changes to the way in which the system works need to be made to ensure our ambulance service is fit for the future. Key among these changes are adapting and achieving consistency in the triage system; giving ambulance staff unrestricted referral rights to community and primary care services and changing the transport model we currently use. These are considered in more depth below.

Triage

There are currently two main triage models in place – NHS Pathways and Ambulance Medical Priority Dispatch System (AMPDS). They both utilise clinical algorithms to determine the appropriate response. Within the 999 service, the majority of trusts have two minutes to undertake a clinical triage before determining the most appropriate level of response. Staff within the NHS 111 service have on average up to nine minutes to complete the clinical triage, which could still result in the dispatch of an ambulance.

Critically ill patients should be identified quickly with a corresponding fast response. For all other patients there should be a clinical triage that is consistent and comprehensive and enables the most clinically appropriate response aligned to the type of incident and clinical need. The NACN would like to work with the Association of Ambulance Chief Executives (AACE), in conjunction with NHS England, to determine what is the appropriate time required to undertake the clinical triage.

We need to connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts. There are a number of ways that healthcare professionals or the public can enter the urgent care system, such as individual CCGs' single-point-of-access schemes, GP out of hours, NHS 111, or 999. This can result in confusion for the public as to which is the appropriate service to use. They sometimes use multiple systems to ensure a rapid response and each part of the system potentially gives different advice. There is also an impact on resources with each part of the system endeavouring to recruit people with similar skills and experience resulting in shortfalls for all.

Consideration should be given to the development of consistent clinical triage across all ambulance providers irrespective of which system they use.

Key summary

- Critically ill patients should be identified quickly with a corresponding fast response.
- There should be a clinical triage that is consistent and comprehensive and enables the most clinically appropriate response aligned to clinical need.
- Consideration should be given to the development of clinical triage across all ambulance providers irrespective of which system is used.

Unrestricted referral rights to community and primary care services

Ambulance services need unrestricted referral rights to community and primary care services any time of the day, either through urgent care centres, mental health crisis teams, facilities for geriatric assessment, respite care, paediatric assessment, maternity and end-of-life care.

This access would support delivery of increased levels of Hear and Treat, Hear, Treat and Refer and See and Treat. Access to a wide range of clinical advice is critical to support the reduction in conveyance to emergency departments. Increases to Hear and Treat and See and Treat give potential opportunities for greater system savings. These could continue to be monitored through a set of system-wide clinical indicators that look at re-contact following discharge via telephone and re-contact following discharge at scene, although there would be a need to ensure consistent data capture.

Response model and measuring success

Standards are important to patients and the public, and play a crucial role in reducing variation across the system and improving outcomes for people. However, there is a danger that where a compliance culture exists, where only targets matter, it can lead to a response model for the ambulance trust that does not align to clinical need or outcomes.

Currently ambulance providers are monitored against three national standards: Red 1, Red 2 and A19, which require either an eight-minute or 19-minute response irrespective of clinical condition at a regional level. The result is a response model designed to 'stop the clock' and potentially inefficient use of scarce resources. Ambulance trusts are performance managed against these targets cumulatively, on an annual basis across their regional contract, with performance fines being mandated for 2015/16. The need to achieve these targets creates some perverse behaviour, such as multiple vehicles being dispatched to a single incident, often to be 'stood down' before arrival.

It is absolutely correct to ensure that those critically ill patients receive a rapid response, but this is not necessarily appropriate for all conditions.

It should also be noted that the red activity only represents a proportion of the total activity, with calls assessed as green accounting for the remainder. If we do not concentrate on the total activity we will not achieve a response model that is fit for purpose. Standards for green activity are determined at a local level but with nationally recommended times.

Work is taking place at a national level on the 'pilot' of a new response standard for red activity, which NHS England will evaluate to understand the factors and learning to be used across all ambulance providers. Any new response standards will need to be clear and the rationale and clinical impact fully understood, with a need to fully engage with the public and other healthcare providers in relation to any changes to the current response model. NACN welcomes the opportunity to work with NHS England and AACE on this development.

As new models of care emerge locally closer to primary care, it will be increasingly important to look to measure success differently. There needs to be development of a range of system-wide outcome-based measures to demonstrate delivery of the new care models, building on the current AQI standards where appropriate. Currently there are a range of quality indicators, particularly in relation to cardiac and stroke conditions, which cover both out-of-hospital and in-hospital periods of care to reflect the effectiveness of the whole acute healthcare system. This methodology and principle could be replicated for any new system-wide outcome measures, with emphasis placed on consistency of data collection and definition to enable robust benchmarking to take place.

There is, however, potential to have significant numbers of key performance indicators across one provider, which needs to be minimised where possible. Examples of how to measure success to support the system keeping people at home and liaise with multidisciplinary teams to do so could include the following:

- consistent non-conveyance levels compared to best practice benchmarks with appropriate use of alternative pathways
- clinical outcome from treatment
- patient experience of treatment in non-acute settings
- patient and clinician experience of waiting time management.

It is clear that commissioners, along with the wider system, will need to work with providers and engage with patients to determine the most appropriate clinical model to support delivery of standardised clinical protocols and sustainable service models, to support delivery of any new response model.

Key summary

- Targets can create perverse behaviour inhibiting the provision of the right care. Any new targets should support care provided in the right place delivering improved outcomes for patients.
- System-wide outcome measures should be developed to measure the impact of new models.
- There must be engagement with patients and providers to determine the most appropriate clinical response model.

Transport model

As part of the move to implement the ambitions around urgent and emergency care, it is proposed to develop centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery. There is an ambition within the Dalton Review to drive standardised clinical protocols and pathways that are agreed across the network of clinicians in the group. This is important for ambulance staff that travel across boundaries who can be faced with a range of alternative clinical protocols and pathways.

Discussions around the development of these specialised centres must include the ambulance providers and commissioners at the early stages to understand the impact on resources. Ambulances will potentially be required to travel further distances to reach the centres, taking them out of their normal locations impacting on the resources available to serve the local area. There would need to be recognition within this proposal for the increased number of inter-facility transfers that would need to take place in order to bring patients back to their local area if they have been taken to a specialist centre for their immediate treatment, or for patients accessing treatment at an alternative setting to the current emergency department.

Currently there are two levels of transport recognised across the system – urgent and emergency, and patient transport service (PTS). Within each area there are also differences around the protocols or criteria to access transport, and a range of providers. With the evolving care models and the drive for more care to be delivered closer to home, there is a need to review the current model with the potential to have different tiers. This could include unplanned, planned and enhanced PTS, which is an intermediate tier within the urgent and emergency care setting.

Planned

This transport tier would continue to cover those patients who require transport on a planned basis, such as attendance at a healthcare facility as part of their ongoing treatment needs, but do not require the staff to have clinical skills.

Unplanned

For those patients with serious or life-threatening emergency care needs that are time critical, there needs to be transport available as and when required with a highly skilled crew who are able to provide full clinical support for the patient.

Across the country there are a number of successful co-responder schemes in place, which utilise the range of skills, to support the rapid response for patients who require a time critical response.

Commissioners support these collaborations between other service providers and the public in achieving high levels of response and appropriate use of resources, providing there is no detrimental impact upon clinical service provision.

Enhanced PTS and intermediate tier

This new transport tier would provide a timed response, (within a set timeframe) for those patients currently classified as 'urgent' who require transport to hospital with the support of staff educated to a designated level.

This group of patients are usually 'booked' between the hours of midday and late afternoon following assessment by a GP or other healthcare professional, and require transport to the emergency department. Depending on demand across the system, these patients can wait for long periods of time, which could result in the categorisation being 'upgraded' requiring an eight-minute response. It can also create 'batching' at the emergency department, thus putting even further pressure on the system.

To achieve an alternative transport model at the pace required and maximise the use of current transport methods, commissioners and providers need to work with other partners or providers to develop partnerships and sub-contract approaches.

Key summary

- We should develop different tiers of transport across the urgent and emergency care setting that are implemented at pace through subcontracting and collaborative arrangements.
- Discussions around the development of specialised centres must include the ambulance provider and ambulance commissioner at an early stage.

Enablers to support change

Some of the enablers for change we believe are within our gift to progress now. Others we believe are not, due to the way the current system works. For example, it is not financially or operationally in the interest of the ambulance trust to spend as much time as is sometimes necessary with a patient, to ensure they are not conveyed unnecessarily, as they need to get back on the road as quickly as possible in order to respond to the next 'job'.

Current response targets and the way the payment models operate do not support the way we want to work – we know the UEC Review recognises this. We would look to encourage a system that incentivises a whole-system approach to increasing safe care closer to home, sharing risk across providers and commissioners alike.

There are a series of key enablers to support the change required. We believe some of these are:

- workforce
- information technology
- payment mechanism
- commissioning models.

Workforce requirements

The NHS Confederation's *2015 Challenge Declaration* acknowledges that the planning, training and support for staff has not changed as fast as people's needs. This is true for the ambulance workforce, who along with other healthcare roles are facing significant challenges in the recruitment and retention of trained paramedics. Not only is there a shortage of paramedics but the training and roles available do not always support a focus on more community-based care to support the patient to remain at home where clinically safe and appropriate to do so.

Health Education England (HEE) with AACE and the College of Paramedics have undertaken a Paramedic Evidence Based Education Project (PEEP) which looks at the need for changes to paramedic training, together with a review of skill mix in the overall workforce, which NACN supports. Due to the high demand across the urgent care system for paramedics and the rate of leavers from the service, we believe that HEE should consider increasing training places across the country and map out with commissioners and providers the future requirements and geographical areas of deficit, so that a realistic plan and timescales can be agreed.

We should also ask whether we need such a heavily weighted paramedic service. Band 5 paramedics currently deliver many aspects of the service patients require, with increased levels of Hear and Treat currently being delivered. We currently

have 'generalist' paramedics, who move between managing patients with routine care needs to those requiring critical interventions. We need to make greater use of those staff with advanced skills and focus these advanced skills across specific elements of care, such as community or emergency needs, rather than all staff focussing on all conditions. This would support a greater level of clinical intervention and multidisciplinary working.

If as a system we are to make the new models of care successful, there will be a need for HEE alongside higher education institutions to work together to align training to the new models of care and the emphasis on out-of-hospital care.

There need to be opportunities for ambulance staff to work across the urgent care system, in settings other than the ambulance trust, to gain and share expertise in the treatment and management of patients within the community, while not detracting from the needs of the ambulance service. We need to start considering the skills required across the urgent care system, map the skills currently available, then understand the gaps which will need addressing. We will then need to develop a realistic route map of how we achieve the change and the associated timeline.

This will require the removal of traditional working boundaries and the coming together of a range of clinical expertise to support the improved management of patients out of hospital. Funding will be required to support these changes to ensure safety and clinical care is not compromised during the transition period.

Many future models will benefit from in-situ paramedics and urgent care practitioners in fixed primary and community settings to which patients can be transported. This workforce may become part of integrated teams with GPs and social care as new models emerge. Consideration should be given to the development of rotation opportunities across sectors for specialist and advanced paramedics, during which time they would remain employed by the ambulance provider.

Information technology

Technology to support the maintenance of conditions at home is being increasingly used as an alternative to conveyance to hospitals, as evidenced by examples of telemedicine supporting patients in their homes. To support the patient journey, ambulance staff must have access to the correct information including patient records. For them to continue to provide the appropriate care, they need easy access to the local directory of service and for staff to use electronic patient care records so that all clinicians involved in the patients care can access the relevant information.

Payment mechanism

Traditional transactional and competitive behaviours, with antagonistic attitudes between providers and commissioners, will not deliver the ambitions contained in the UEC Review.

System-wide changes to the payment mechanism and how these will be played in to system-wide savings will need to be developed along with a model of risk and reward sharing among providers and commissioners for the delivery of service outcomes rather than inputs.

The current tariff is too sensitive to changes that impact on overall costs, resulting in risks to both provider and commissioner, and is not consistent with a speed of response model. There needs to be recognition of the costs of delivering a 24/7 response model in both an urban and rural area with the payment mechanism reflecting this.

We are concerned that the Monitor proposals seek to protect fixed costs of providers. Commissioners believe that unless the payment mechanism supports transition of fixed costs to other community and primary care settings then the transformation required will not happen.

We should also consider the use of other financial incentives, such as Commissioning for Quality and Innovation (CQUIN) payment schemes, to support modernisation across the urgent and emergency care network, but these would need to be over a number of years and not just schemes covering one year.

Commissioning models

Commissioners have varying levels of understanding of the role of the ambulance provider. With the development of the collaborative commissioning for ambulance service provision this has created what could be described as a niche area of commissioning.

The majority of contracts for emergency ambulance provision are negotiated on a regional basis by a lead CCG under collaborative commissioning arrangements, using either a block contract or cost and volume contract for a one-year duration, designed to deliver national performance standards at a regional level.

Local commissioning

NACN recognises that the ambulance service currently delivers a regional delivery model with local adaptations, and with the evolution of increased examples of integrated care models and new commissioning models, commissioners will need to continue to collaborate across larger footprints to ensure resources are maximised efficiently and deliver services differently.

There are examples across the country of CCGs developing provider/commissioner alliance contracts to support horizontal integration to assist the development of integrated care models and the development of specialist intermediate care, with a range of outcome-based measures to demonstrate delivery of the new care models. These contracts would cover an element of the current ambulance function, but the aspects around the continued requirement for an emergency response would remain. Contracts would also be required over longer-term duration, rather than the one-year contracts currently in place, to enable change to be embedded across the system.

Commissioners need to move from the current contracts for services, to commissioning for outcomes focused around patient and clinician experience and patient outcomes.

Collaborative commissioning across the ambulance providers remains an appropriate model until the changes across the urgent care system are in place and clear.

National commissioning

With the advent of devolution of health and care budgets across combined authorities, consideration will need to be given to the impact that would have on delivery of regional and national resilience for the ambulance provider.

There is currently a requirement for the ambulance provider to support national resilience through specialist functions. With the growing specialist nature of some of the functions the ambulance provider is now expected to deliver, over and above core business, discussions need to take place to consider how this will be commissioned and delivered in the future. The view of the NACN is that ambulance service provision required to support national resilience should be commissioned at a national level, particularly with regard to specialist functions covered by the emergency preparedness response and recovery (EPRR) core standards, for example the Hazardous Area Response Team (HART).

Key summary

- Ambulance commissioners want to work closely with HEE and AACE to agree workforce and training plans.
- There is a need to support ambulance services and workforce to diversify into providing multidisciplinary responses in situ as well as mobile units.
- We should continue to commission ambulance service provision via collaborative commissioning arrangements.
- There is a need to move to commissioning for outcomes rather than current contract for services.
- National specialised commissioning should commission specialist ambulance provision, such as HART to ensure expertise in commissioning is not diluted and capability is assured.

What is NACN doing to create the changes needed for the future?

- NACN will continue to work with a range of stakeholders to promote and take forward the key messages contained in this discussion paper.
- We will work with the urgent and emergency care team at NHS England to support the move to implementation of the outputs from the review.
- We will support the work on the development of an appropriate clinical triage model that supports delivery of any new response model.
- We will continue to proactively influence national policy through engagement.
- We will continue to share learning across the commissioner network.
- We will continue to proactively engage with ambulance providers to support development and delivery of new models of ambulance provision.
- We will continue to promote the ambulance commissioners network to CCGs, ensuring we can communicate effectively with all CCGs.
- We will continue to work with HEE and AACE on the development of the ambulance workforce model.

Glossary

Hear and Treat: This is where a clinician in the ambulance control centre speaks to patients or their carers, and gives advice over the telephone once they have assessed the patient's condition and ruled out any potentially life-threatening or urgent medical conditions.

Hear, Treat and Refer: This is where a clinician in the ambulance control centre speaks to patients or their carers over the telephone, and once they have assessed the patient's condition and ruled out any potentially life-threatening or urgent medical conditions refers them to a local service, such as their GP, that is more appropriate to help the patient.

See and Treat: This is where patients are treated at the scene by ambulance staff, rather than being taken to hospital.

Contact us

If you have any queries about this paper or would like further information about the NACN, please email **office@nhscc.org**

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NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice from the front line to the wider NHS, national bodies, government, parliament and the media. Our networks provide members with the opportunity to share experience and expertise; and provide information, support, tools and resources to help CCGs do their job better.

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