ASSOCIATION OF
AMBULANCE
CHIEF EXECUTIVES

Association of Ambulance Chief Executives (AACE)

Strategy 2020-2023

Written and developed by:	Reviewed by:	Approved by:	For information:
Anna Parry, Deputy Managing Director, AACE Martin Flaherty, Managing Director, AACE	AACE Council	Ambulance Chief Executives' Group	AACE Council
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Foreword

I was delighted to be elected AACE chair by my ambulance service chief executive colleagues in summer 2020. I have worked in the NHS for over 32 years, 29 of which have been in the ambulance sector, and am immensely proud to have been given the opportunity to serve as AACE chair for three years.

In the context of the first wave of the Covid-19 pandemic, as well as my new position as chair, I was keen to work with colleagues to review AACE's strategic priorities to ensure that our focus remains aligned with our members' priorities and aspirations, as well as being contextually appropriate.

This three-year strategy has been produced following extensive consultation on AACE's governance structure and priorities with chief executives, chairs and national director group leads. I have also had a considerable number of meetings with external stakeholders during the initial months of my chairmanship, feedback from which has also informed the strategy's development.

This is as an overarching strategic document, which underpins all the work undertaken by or on behalf of AACE by both its core team as well as its member organisations.

At the commencement of its production, the intention was to develop annual strategic plans for the three years of my chairmanship, however, given the ongoing Covid-19 pandemic, comprehensive annual strategic plans will be developed for 2021/22 and 2022/23. For the remaining months of the current financial year, however, AACE's strategic focus will align with the priority areas outlined in the document.

I am incredibly proud of all our ambulance staff and volunteers across the UK who do an amazing job day in day out serving their local communities, and I look forward to working with colleagues, both within and outside the ambulance service, in progressing this strategy over the coming three years to ensure continual improvement and advancement for our patients and staff alike.

Daren Mochrie QAM

Chair, Association of Ambulance Chief Executives

November 2020

Overview

1. The Association of Ambulance Chief Executives (AACE) was established in 2011 to provide ambulance services with an organisation that can support, co-ordinate and implement policy in a consistent way nationally.

   We, the Association, also provide the public and other stakeholders with a central resource of information about NHS ambulance services.

   Whether for patient care, operational policy or emergency preparedness, the Association exists to supports its members and, where appropriate, to act as an interface between them and their stakeholders.

   We provide a structure to co-ordinate, manage and implement key national work programmes and policy that are fundamental to the ongoing improvement of UK NHS ambulance services and advances in patient care.

   We also provide bespoke support to our members over a wide range of areas covering transformational change and operational development. This is provided by the AACE core team supported by a growing range of senior consultants with extensive experience of working in ambulance services at CEO or director level within the UK and internationally. All funding generated through this work is used to provide additional membership support activities.

2. The chief executives of all ten English NHS ambulance trusts and the Welsh Ambulance Service (as of April 2021) are our full members. Our associate members are chief executives of ambulance services operating in the other devolved administrations, and the Republic of Ireland. The Isle of Wight, the Isle of Man and the Channel Islands (Guernsey and Jersey), along with the British Overseas Territory of Gibraltar, are also associate members.

   English and Welsh ambulance service chief executives have all the rights expressed in the AACE Articles of Association whilst associate members have the right to be present and to speak at general meetings but not the right to vote at any such meetings or to count in the quorum.

3. As well as working closely with chief executives across the UK NHS ambulance service, we collaborate extensively with ambulance service chairs, directors and other trust employees with the ultimate aim of improving the sector for patients, staff and volunteers. Determining where there is tangible value in adopting a national approach to risks and opportunities is fundamental to our focus and the work we undertake with and on behalf of the sector.

4. AACE has historically determined its strategic priorities on an annual basis with chief executives and chairs of member trusts. In the context of the first wave of the Covid-19 pandemic, as well as the appointment of a new chair who assumed the role in August 2020, we have reviewed the priorities originally determined for 2020/21 during summer 2020. We have subsequently produced this strategy which covers the three-year duration of the chair's tenure.

5. The purpose of our strategy is to outline to members and external partners what AACE is about, its vision, and our strategic focus for the next three years. The outlined strategic

priorities have been determined through engagement and discussion with chief executives, chairs and directors from our member trusts, as well as liaison with external partner organisations.

6. To ensure AACE remains compliant, resilient and sustainable, we must manage our own risks whilst communicating regularly and effectively with our members, our partners and stakeholders. As such, oversight of this strategy will be undertaken at AACE Council meetings, which comprise chief executive and chair representatives from all member trusts, full and associate, and take place three times a year.

Our vision

To champion and deliver ongoing improvement across the UK NHS ambulance sector to benefit our patients, our people and the wider health and social care system

7. The Association recognises that our member trusts each have their own vision and how we differ from them in that our primary role is representing them rather than delivering urgent and emergency care services. However, all our trusts share a desire to continually improve the experience of patients and their employees and volunteers, which we strongly echo and are committed to supporting.

Our membership offer

8. The activity that AACE undertakes on behalf of its members can be separated into three distinct areas:

- Co-ordinate and facilitate
- Produce and deliver
- Lobby, influence and communicate

9. *Co-ordinate and facilitate:*

We co-ordinate regular meetings for chief executives of our member trusts, which generally occur on a monthly basis. We co-ordinate meetings for chairs of our member trusts and

combined meetings for chief executives and chairs three times a year. We facilitate the coming together of a number of national director groups on a regular basis providing assistance in areas such as administration, project management, data collection and seeking subject matter expertise and input.

In order to share best practice and drive improvement or arrive at a sector view or position in relation to a given subject area, we commonly bring together representatives from our member trusts and support their collaborative working. This may be within specific professional disciplines, such as human resources or operational management, or when cross-professional solutions are required.

A further key area of AACE's co-ordination and facilitation activity is oversight of and contribution to the development the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical guidelines. These guidelines have evolved from locally-derived protocols to systematically-developed national clinical practice guidelines. Through their national adoption, standardised, evidence-based care is ensured with improved clinical outcomes resulting for patients. The guidelines were previously published in a five-year cycle but due to the rapidly developing evidence base and the emerging technological options for publication, the guidelines are now updated on an ongoing iterative basis, with close support from the AACE core team.

10. *Produce and deliver:*

We regularly produce and deliver specific pieces of work on behalf of the sector such as the commissioning of research or the development of a policy or guidance documents; respective examples are the AACE suicide study, findings from which were published in November 2017, and the AACE national falls response governance framework published in September 2020. We will commonly work alongside representatives from our member trusts to ensure appropriate subject matter expertise and that the given output is fit for purpose.

We are also regularly commissioned by our member trusts on an independent basis to undertake discrete pieces of support including:

- Mentoring of chief executives and senior managers;
- Reviews of various operational service lines;
- Support with demand and capacity reviews;
- Support with organisational transformation, cultural change and operational development.

Furthermore, external organisations, such as NHS England and NHS Improvement, commission AACE to undertake improvement work on their behalf where ambulance service subject matter expertise is required. Each of these areas of work with external organisations needs to be endorsed by the Association's full members; its focus is on quality improvement with the income generated supporting the Association's core work and offer to members.

11. *Lobby, influence and communicate:*

AACE provides an independent voice for all trusts that comprise the UK NHS ambulance sector and can subsequently seek to campaign and influence on behalf of the sector in a way that its members, on their own, cannot. We communicate and liaise extensively with national

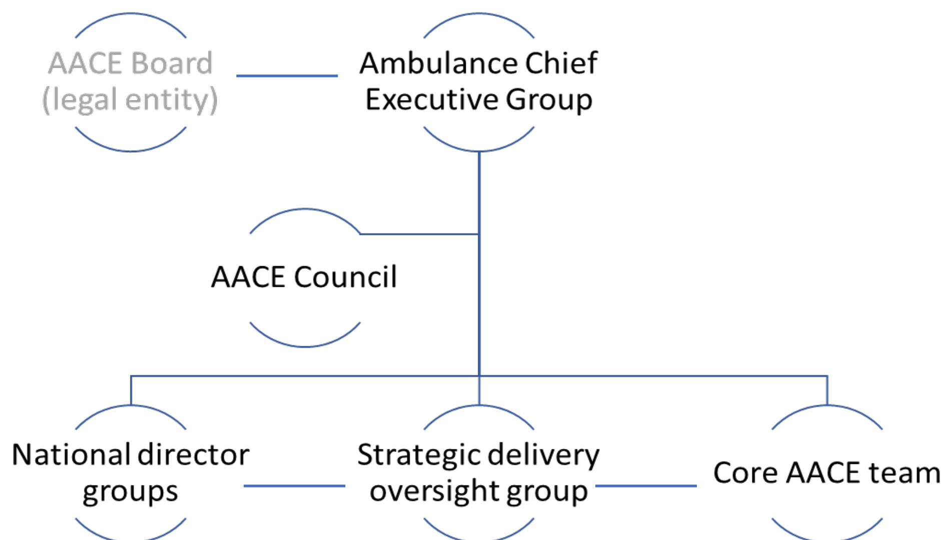
media on behalf of the sector in relation to topical subjects and incidents as well as ongoing issues that affect the ambulance service, such as violence and aggression against staff and handover delays.

We also engage and liaise with a considerable number of external partners across the UK on behalf of the sector where there are common, consistent messages to convey; these include NHS England and NHS Improvement, Health Education England, the College of Paramedics, the Care Quality Commission, the National Police Chiefs Council and the National Fire Chiefs Council,. Furthermore, we are a committed and proactive member of the Global Paramedic Leadership Alliance working with colleagues to share best practice and learning internationally to advance the paramedic profession and the ambulance/emergency medical service's provision of care.

We work alongside other member organisations, such as NHS Providers and NHS Confederation, to ensure that the ambulance service voice is heard and reflected in policy and communications, and also seek to influence governmental and national NHS bodies.

How we work

12. The diagram below shows the operating model for AACE:



13. AACE is chaired by a chief executive from a full-member ambulance service elected by other full-member chief executives in line with AACE's *Arrangements and Operating Principles.* The chair is elected for a term of three years and can stand for one subsequent term if formally re-elected to do so by member chief executives.

14. The Ambulance Chief Executive Group (ACEG) generally meets monthly and is chaired by the AACE managing director with meetings open to full and associate member chief executives. AACE accepts that trusts are autonomous organisations responsible to their respective boards and, as such, must retain the final decision on whether to adopt a national position determined by the Association. That said, AACE is committed to attempting to secure a national position wherever possible on issues where this is deemed to be desirable by its members in line with its *Arrangements and Operating Principles*.

15. The Council comprises all English and Welsh ambulance service chief executives and chairs and is a committee established by the AACE. It is not a legal entity. Other devolved ambulance service chief executives and chairs are invited to attend Council meetings and contribute to discussions. The Council plays an important role in determining AACE's strategic direction and overseeing its realisation.

    The AACE Council is chaired by a chair from an English or Welsh ambulance service elected by chairs from other full-member trusts in line with AACE's *Arrangements and Operating Principles*. The Council chair is elected for a term of three years and can stand for one subsequent term if formally re-elected to do so.

16. Reporting into the ACEG are several national director groups and the national ambulance diversity forum (NADF). These comprise directors (or representatives in the case of the NADF) from English and devolved ambulance services from the respective directorate area, for example, finance and medical. The purpose of the groups is twofold: firstly, to provide individuals with an opportunity for networking and best practice sharing and; secondly, to progress pieces of work required by AACE to deliver against strategic priorities or in their specific discipline area, as agreed by the ACEG on behalf of respective trusts.

17. A number of sub-groups report into the national director groups. The respective national director group is responsible for ongoing review of its sub-groups' continuation; if a group is no longer adding value or deemed useful, it should no longer continue to meet/operate. Sub-group priorities and work plans should be informed by the AACE's strategic priorities in accordance and alignment with the work plan of the respective national director group.

18. AACE is a members' organisation constructed as a private company limited by guarantee and regulated by the Companies Act 2006. The AACE Board exists to manage the organisation in accordance with those regulations.

19. The AACE core team reports into the AACE managing director. The team supports work undertaken on behalf of member trusts across the activity areas outlined: co-ordinating and facilitating; producing and delivering; and lobbying, influencing and communicating.

20. The AACE contractors support both core AACE activity and bespoke commissioned activity and report to the managing director for these areas of work.

21. The strategic delivery oversight group is responsible for co-ordinating and overseeing the delivery of AACE's annual strategic plan and is chaired by the AACE chair. It comprises chairs from national director groups as well as representatives from the ambulance chief executive group and the core AACE team.

Our strategic priorities

22. To help us determine our strategic priorities for 2020-23, we have undertaken a strength, weakness, opportunity and threat analysis on behalf of the sector, which is shown below. The emergent priorities are primarily a response to the opportunities and threats presented – considered in the context of the sector's strengths and weaknesses.

Strengths:

- Unique position as regional providers
- Close working at a national level through AACE; scope to share best practice/learn from each other/support each other – demonstrated throughout Covid-19
- Able to develop strong national positions, guidance, policies collectively
- Powerful, collective voice – ambulance service in its entirety
- Data-rich
- Resilience across sector – to ensure national delivery
- Relationships with external stakeholders: NHSE/I; College of Paramedics; Health Education England; police and fire; NHS Confed/Providers etc
- Data rich – contribution to population health management in integrated care systems

Weaknesses:

- Regional footprint at odds with system-level footprints and commissioning landscape
- Increasing operational pressures and demand
- Have historically been seen by some as insular
- Small part of NHS/proportion of spend circa 2% of spend – can be hard to get voice heard
- Stretched from resource-perspective: frontline staffing/managers/senior team to engage/influence at sector-level
- Emergency service and NHS provider – straddle both; not fully aligned with either; can impede clear communication re role/potential across health and social care
- Some challenging areas relating to trust culture e.g. bullying and harassment; racism

Opportunities:

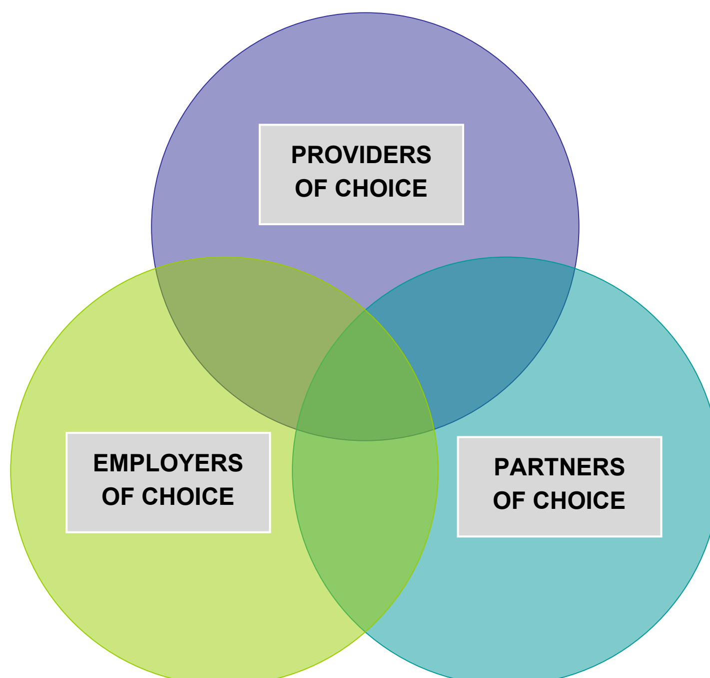
- Unique offer as system-leaders with regional view/ understanding/ footprint; trusts gaining increasing experience and learning in this space
- Scope to improve patient experience in relation to joined up care delivered at the right time in the right place
- Embedding rotational working – a system-solution with considerable benefits at employee/organisational and system levels
- Long term plan commitments to mental health within the ambulance service
- Spotlight on BME populations during Covid-19: springboard to do better by BME patients and employees
- 111 First – huge potential impact on system and patient flows, which the ambulance service can play a key role in

Threats:

- Ongoing Covid-19 pandemic – sustained periods of operating under considerable service pressure and strain
- Focus on Covid-19 detracts from progress in strategic areas at a national level e.g. non-urgent patient transport service review
- Risk of greater workforce shortages posed by policy in other areas of NHS – as well as issues re workforce retention
- Impact of ambulance service work on employee mental health and wellbeing – exacerbated by Covid-19
- Insufficient funding to meet existing resource requirements and enable the sector to embrace opportunities e.g. 111 First
- Inequity in care provision – for patients with protected characteristics
- Small AACE core team with limited capacity

23. We have identified three high-level strategic priority areas for the coming three years following consultation with our member trusts as well as discussions with external stakeholders:

SUPPORTING THE UK NHS AMBULANCE SECTOR TO BECOME…



24. *Providers of choice:*

Aspiration: the public view ambulance services as a reliable, high-quality service provider when they have an urgent or emergency healthcare need.

We are committed to supporting continuous advancement in all areas of ambulance service activity and business and nurturing learning organisations that share best practice to improve care delivery. This includes clinical development, in relation to physical and mental health, operational transformation, and digital modernisation with patients as the ultimate beneficiary. Ambulance services work on a regional basis and patients are not able to 'choose' their preferred provider, however, striving to be the preferred provider – in terms of quality, effectiveness and efficiency – is fundamental to our work. Sharing best practice and learning from each other is a central element of this.

The Covid-19 pandemic has presented the ambulance service, alongside other health and social care providers and emergency services, with an unprecedented, sustained and substantial challenge. Ambulance services have worked tirelessly throughout the first and second waves at regional levels and, through AACE, collectively and constructively to simultaneously deliver a cohesive national response. More effective ways of working have been introduced in relation to some elements of care delivery and organisational approaches, which we have sought to maintain where there is clear, demonstrable benefit for patients and employees.

25. *Employers of choice:*

Aspiration: people view ambulance services as organisations that they would be proud and wish to work for.

People are integral to and at the very heart of the services we provide to patients. It is essential that the sector has a sufficient number of well-educated and trained, well-equipped, well-led and well-supported staff to meet the care needs of the population we serve. Becoming a preferred employer is intrinsically linked to the sector becoming a preferred provider. Key areas of focus in our quest to become a preferred employer include tackling racism at all levels across the sector, putting equality, diversity and inclusion at the heart of all we do, leading compassionately and developing compassionate leaders, and prioritising the mental health and wellbeing of employees. Strong operational and clinical leadership is essential and ensuring a sufficient workforce pipeline for registered and non-registered clinical roles.

26. *Partners of choice:*

Aspiration: systems view the ambulance service as a key partner or leader in the collaborative delivery of urgent and emergency care.

The ambulance sector has traditionally been the statutory provider of 999 emergency medical services and, as such, has been strongly affiliated with police and fire and within health, primarily emergency departments. Its focus has increasingly moved into the realm of urgent and emergency care provision, however, with eight out of eleven English and Welsh trusts providing some 111 services, four of which provide all 111 services within their respective region. Eight out of ten English and Welsh trusts also undertake some or all of the patient transport service provision within their region. Provision of 111 services – or their equivalent – and patient transport services is also undertaken by ambulance services in other devolved nations.[1]

In the fluid and ever-evolving world of health and social care in England, as well as in devolved nations, working collaboratively alongside other partners is becoming increasingly important for the ambulance sector. In England, engagement and liaison with regional NHS England and NHS Improvement teams, as well as strategic transformation partnerships, integrated care partnerships and primary care networks at a more local level, is imperative if

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[1] the numbers contained in relation to ambulance service provision of 111 and patient transport services may be subject to change during the lifespan of this document in the context of commissioning decisions

ambulance services are to contribute meaningfully to system-level improvements in patient care. Given its regional status, the ambulance service also has a unique system-leadership role to play at regional and system levels whilst at the same time ensuring that services are tailored to local authority/borough at a place level and local communities at a neighbourhood level too.

27. Our three strategic priorities are not standalone; they are all inter-related with progress in one area invariably contributing to progress within the others. We would not seek to support or endorse activity within one that would be of detriment to another, whilst activity undertaken in each priority area is always considered in the context of the others.

How we deliver

28. Our strategic priorities underpin all of AACE's activity as well as that of national director groups and their respective sub-groups. The majority of national director groups will have a contribution to make to all three priority areas, be it directly or indirectly, with some more aligned to one of the priorities than another.

29. Where specific pieces of national work are required to deliver against our strategic priorities, a project management 'light' approach is used with a one-page project initiation document (PID) completed clearly determining scope, benefits, project team members, deliverables and timescales.

30. The intended activity that will be undertaken to deliver against our strategic priorities, both that specific to individual national director groups and within cross-professional projects, will be captured in AACE's annual strategic plan.

31. To ensure alignment across national director groups and in delivery against the identified priorities, a strategic delivery oversight group, comprising chairs from all national director groups, will generally meet on a quarterly basis. This group is chaired by the AACE chair and is responsible for: approving PIDs where projects have a strategic focus and require input from more than one national director group; and overseeing progress against the strategic plan. In relation to the former, a key role of this group is determining whether the project will add sufficient value at a national level to justify the use of the finite resources available i.e. balancing benefits versus cost.

32. The ACEG fulfils the role of programme board with a chief executive sponsor identified for projects when deemed appropriate. In some instances, a sponsor from the ambulance chairs' group may also be identified.

How we manage risk and opportunities

33. Given the uncertain and evolving context of Covid-19, as well as potential changes in the NHS structure and legislative framework within which the ambulance service operates during the life-span of this strategic plan, risks and opportunities will inevitably be subject to flux.

34. We have a strategic risk register, created and managed by the Quality, Governance and Risk Directors' Group, which is reviewed quarterly by the strategic delivery oversight group with risks escalated to the ACEG as required in accordance with the risk management protocol.

35. Opportunities are managed across all elements of AACE business – within national director groups, by the strategic delivery oversight group, by the ACEG and by the AACE Council. In alignment with the risk oversight role fulfilled by chairs within their respective trusts, review of the risk register will feature as a standing item on quarterly AACE chairs' meeting agendas.

How we communicate and engage with our members

36. We are acutely aware that if we are to represent our members well, communication and engagement are essential. Furthermore, our members play an intrinsic part in us progressing and achieving in our identified priority areas.

37. We have an AACE communications strategy and a comprehensive collection of AACE lines relating to key topic areas where responses to media enquiries have previously been requested. We produce an update every quarter capturing key activity within each of our strategic priority areas, which is shared with chief executives, chairs and national director groups for onward circulation across trusts as desired. We also produce a comprehensive annual report each year which is distributed to members and key stakeholders.

38. We have an identified link from the core AACE team for each of the national director groups and a number of AACE representatives at ACEG, Council and strategic delivery oversight group meetings, all of which the AACE core team co-ordinate.

39. We promote and facilitate the use of Basecamp – project management and team communication software - as an online communication tool, which is available for all national director groups, sub-groups and chairs. We also use WhatsApp as a fast, secure and reliable messaging service where there is an identified desire amongst member groups.

40. We have a chief executive lead identified for each of the national director groups who provides a point of contact for the chair into the ACEG. They also have responsibility for communicating and engaging with fellow chief executives as required in relation to their respective lead area. As outlined above, where a need for a chief executive sponsor is identified for specific projects within strategic priority areas, the respective chief executive is responsible for communicating and engaging with the ACEG and updating on progress.

How we report back to our members

41. On an annual basis, national director groups and their respective sub-groups each update on their delivery over the previous 12 months against our strategic priorities. They simultaneously update on plans for the following 12 months, again, against our strategic priorities. Given the number of sub-groups, national director groups are responsible for approving delivery and plans for their respective reports whilst national director group delivery and plans are reported to the AACE Council. The output from this process informs the annual strategic plan.

42. Three times a year, progress against the annual strategic plan is reported back to chief executives and chairs at the AACE Council in alignment with the delivery approach outlined above.