The Association of Ambulance Chief Executives (AACE)

*Response on behalf of the statutory ambulance services/trusts in the UK.*

# AACE submission to Change NHS for the 10-year health plan

Associated documents/resources:

**A vision for the ambulance sector in co-designing UEC provision (March 2024)**

**AACE response to Lord Darzi review (September 2024)**

**Re-envisaging urgent and emergency care (NHS Confederation December 2022)**

## Q1 What does your organisation want to see included in the 10-Year Health Plan and why?

1.1. Recognition that the current model for urgent and emergency care (UEC) is not working and so 'patching or topping things up' to do more of the same, in the same ways, will neither address the current priorities nor the forecasts of changing demographics, increasing co-morbidities and projected patterns of illness. Essentially, the plan needs to shift investment to community services, social care, GPs and ambulance services (reducing pressures on secondary care) to improve appropriate care for patients now and in the future.

1.2. Re-design of the UEC model is needed, with ambulance services proactively included, with other providers, in strategic planning at regional and system levels, with the following primary remits:

a. To provide **life-saving response to patients needing emergency and seriously urgent out-of-hospital care**, with more direct referral pathways to other parts of the system for lower-acuity calls, including out-of-hours.

**Why?** Because if we are to fix our EDs we need to reduce the flow into them. Access from 999 and 111 and for clinicians on scene (via care-coordination hubs, as above) to a wider range of primary, secondary, community and mental health pathways will improve patient experience (right care first time, fewer touch-points and repeating stories) and outcomes. This in turn will reduce pressure on resources for C1 and C2 ambulance responses and emergency departments, allowing them to focus on the sickest patients (see also point 2.14). Ultimately, if we are getting it right first time, only those patients who *need* a double-crewed ambulance for treatment and conveyance to ED, will receive one.

b. To be the **lead coordinator and navigator for unscheduled UEC demand via 999 and 111**, with call-handling at regional level and multi-professional, care-coordination hubs (single points of access) at ICS/health board level, linking seamlessly with place-based / neighbourhood services. This way, the NHS can deliver appropriate, timely, co-ordinated patient-centred care, moving care closer to home, ensuring emergency resource is available for those who need it most, thereby improving patient outcomes and experience.

   **Why?** Because 999 and 111 are co-dependent services and the data shows us that there is a significant amount of avoidable conveyance in the demand coming through 999 and 111. Establishing these services for regional level / ambulance footprint can greatly increase efficiency and avoid duplication by pooling resources – especially important as we know there are shortages of key clinical roles in paramedicine, medicine and nursing. We need to design joined-up, truly integrated, service provision so that the patient is at its heart and not being bounced from pillar-to-post to get to the right care, as happens now due to multiple access points, sector boundaries and siloed governance structures.

c. In addition to these two primary remits, having community paramedicine models available on a greater scale with broadened, advanced skill sets (including prescribing and near patient testing) will enable paramedics to safely keep *more* patients at home than already achieved through see & treat models, as well as play a more active role in ill health prevention.

1.3. Consolidating and appropriately commissioning the role of ambulance services in urgent care provision, in a co-designed and integrated way, with a shift of investment into out-of-hospital care provision. This would mean that ambulance services can safely and effectively provide appropriate urgent care responses by making more widespread use of specialised and advanced skills of paramedics in community paramedicine, whilst supporting other out-of-hospital sectors that currently struggle with resourcing same-day urgent care provision (i.e. primary, community, mental health and end-of life care).

**Why?** Because the reality is that ambulance services are already providing substantial urgent care, as a trusted 'brand' available 24/7, that the public turn to in their time of crisis. Other, out-of-hospital services providing urgent care are currently either depleted (e.g. mental health crisis teams, primary care, falls services, end-of-life services) or unavailable (e.g. limited hours and scope) and require greater investment to build these up, which will take time. Ambulance services, commissioned appropriately, can reduce pressures on other parts of the system, particularly primary care, so those health care providers (HCPs) can focus on their respective speciality of care provision. **By safely closing more episodes of care in our communities we can shift the balance away from secondary care, releasing capacity for elective work.** This in turn will remove the experience of ambulances being held for long periods outside hospitals, with all the adverse effects for both patients and staff. By having ambulance resources available where and when they need to be, we can improve not only emergency responses, but also the out-of-hospital responses from all providers and join up the wrap-around care that patients expect and will benefit from.

1.4. For design and implementation of the 10-year plan to be successful there also needs to be clarity and agreement on who is accountable for what – with clear remits for NHS England and Integrated Care Boards (ICBs). There are currently too many 'grey areas' for this which hinders progress and improvement.

**Q2** **What does your organisation see as the biggest challenges and enablers to moving more care from hospitals to communities?**

## Challenges:

2.1 **Silo-working:** Re-design to achieve this shift requires genuine, tangible, integration and co-production across the UEC pathway. This is not helped by the current structures within NHS England having separate teams for UEC and ambulance, that often seem disconnected. We need a single team focussed on UEC in the round. Ambulance services need to be right in the mix with other UEC provision and commissioning, for strategic and workforce planning, and monitoring of patient outcomes and experience across the pathway.

The biggest barrier we have is thinking in silos (NHS Confederation – Matthew Taylor and Daniel Elkeles February 2023)

2.2 **Ambulance commissioning:** the current model of ambulance trusts being 'hosted' by a single ICB does not work well for commissioning or strategic planning purposes given the ambulance sector's regional footprint. It also poses significant problems in relation to capital allocations for the ambulance services who have to bid, via their host, for individual ICB allocations. They are subsequently often overlooked, because the requirements are regional and thus outside the host ICB footprint. Allocations are also often agreed too late for forward-looking business cases needed for transformation and improvement initiatives. A report recently published by NHS Confederation found that there is a £146m backlog of estates maintenance for ambulance services, who report receiving less than half the capital they require for this. On top of this, political pressures driven by misguided local public opinion that ambulance station proximity represents the 'best service', is often obstructing some ambulance service proposals to transform their estate (decreasing the number of premises), to have efficient and effective Make Ready hubs - "Without significant capital investment in estates, [ambulance] trusts will struggle to improve integration with other sectors through new digital systems; meet the NHS's commitment to reach net zero by enhancing energy efficiency within ageing buildings; or provide the charging facilities needed to enable the shift to an electric ambulance fleet."

2.3 **Resource allocation:** shifting funding/investment/clinical workforce into out-of-hospital same-day and urgent care services has historically been resisted, and more so now with the focus on elective care backlogs. Expanding resources in these specialties needs to be a priority if capacity in acutes is to be released to manage elective work.

2.4 **Availability of out-of-hospital teams:** most community-based teams/pathways for unscheduled care do not operate 24/7, and do not always have the capacity to meet demand, so default out-of-hours is to ambulance/ED – need to analyse existing data and predicted health and demographic trends to assess which services are needed, when and where, for same-day care.

2.5 **Risk aversion:** most other services will not consider a patient presenting with acute chest pains or breathing difficulties; hence the system directs them to 999, and many do not need an ambulance response (see point 2.14).

2.6 **Barriers to access:** addressing geographical and logistical barriers to ensure equitable access to community-based services e.g. advanced practitioner roles / community paramedicine models are provided in pockets (mainly rural settings) and need to be more widespread.

2.7 **Trusted assessors:** ambulance clinicians have limited access to healthcare records and in some settings are not yet seen as trusted assessors and therefore do not have ready/direct access to refer into other services in the community setting; this hinders getting patients seamlessly into the right care.

2.8 **The ability to share patient information** across a number of professionals and services is essential to safe care out of hospital. There are currently many platforms across UEC which don't talk to one another and lack of data sharing agreements mean risk has to be avoided by conveyance; there is less efficiency and a poorer experience for patients who have to repeatedly share the same information with multiple professionals.

2.9 **Additional Roles Reimbursement Scheme (ARRS)** in its current form does not support efficient and effective role for paramedics working on a rotational basis with primary care and portfolio working. This needs revisiting and revising.

2.10 **Lack of social care resources** is stifling patient discharge from hospital and limits our ability to keep frail/elderly/disabled out of hospital when their needs are primarily an increase in personal care for a non-serious illness.

2.11 **Lack of advanced emergency treatment plans** to support adherence to patient wishes and provision of appropriate care in end-of-life stages. These are not routinely being talked through by GPs and other HCPs with patients and families at appropriate stages, and if they are in place, are often not readily available for ambulance clinicians when attending on scene.

## Enablers:

2.12 **A fit for purpose commissioning framework for ambulance services** that is less concerned about speed of response and more concerned with patient outcomes and experience, secondary prevention and supporting wider system delivery in reducing health inequalities. AACE has called for an agreed national approach to commissioning to reduce regional variation and ensure that patients get the same level of high-quality equitable care no matter where they live. This is currently being impeded by different regional approaches to commissioning with some areas prioritising the achievement of financial balance while others prioritise delivery against statutory clinical standards. We need a nationally agreed model for regionally-based, strategic commissioning, ensuring equity of access to unscheduled UEC, whilst enabling place-based pathways development that own population need at neighbourhood level, to provide equitable care no matter where you live. This needs to consist of longer-term financial allocations, for both capital and revenue, to facilitate planning, transformation and sustainability.

2.13 **Collaborative frameworks:** establishing partnerships, particularly for ICS level care-coordination hubs, with primary care, community services, and social care will support seamless transitions for the patient in receiving the care they need, often from several services. These hubs will also identify gaps in services that can be highlighted/addressed through UEC commissioning.

Examples of multi-disciplinary, system-based care-coordination hubs being led by ambulance services are growing, but we need more of these and fewer SPOAs and CASs operating on smaller footprints trying to do the same in a limited way.

An extended example of navigation support is in London, where LAS are successfully providing GP Support Services (GPSS) using existing telephony structures to take GP calls, enabling GPs to better focus on their patients needing same-day access and reducing the number of patients defaulting to 999,111 or ED when they cannot get a GP appointment. Findings from this small-scale project working with 5 GP practices, are already indicating higher patient satisfaction, happier staff in GP practices, a bigger use of pharmacies, patients who need emergency care getting it much quicker and a c20% reduction in the use of 111 and ED for the patients of these GP practices. Financial evaluation shows that for every £1 spend on investing in the GPSS, the NHS could save £2. Extrapolated across London there would be up to 750,000 fewer ED attendances in London in a year.

2.14 **Review of the needs of Cat 2 and Cat 3 patients** - when we look at the clinical data, very few Cat 2 patients have an immediate care need requiring hospital (e.g. stroke), they have an urgent care need. In reality only about 1 in 5 to 1 in 10 need that immediate response to hospital. There is potential, therefore, for game changing interventions in the response model for many other Cat 2 patients (e.g. chest pains, breathing difficulties – high volume and difficult to manage remotely), where once assessed, time is not critical but other forms of care are. Likewise, some Cat 3 patients actually need a quicker response than the designated standard for this category and are currently receiving responses way beyond these times, resulting in poorer outcomes. Ambulance services have the skills, coordination, workforce and footprint to better manage these presentations, however, our current commissioning and clinical model assumes all Cat 2 patients need conveyance, and Cat 3 patients can all wait longer for a response. We do need 'eyes on' to differentiate which need an ambulance/conveyance and which do not, but this need not necessarily involve a double-crewed ambulance response in the first instance - could be a single paramedic in a car, or even make use of video consultations where appropriate. Reviewing these categories could greatly help in making best use and availability of ambulance resources for the sickest patients.

2.15 **Interoperable infrastructure** which allows for real-time multi-disciplinary conversations about patients with all professionals having access to all the relevant information to keep that patient safe at home.

2.16 **Reduce variation in NHS111 and same-day UEC care provision (e.g. SDEC, UCR)** by having clearer specifications, with limited scope and rationales for when localised variation may be appropriate. ICBs then commission these services and can be held to account for meeting those requirements.

2.17 **System workforce planning:** to develop an empowered, resilient, skilled UEC workforce supported by flexible career pathways. Paramedics are sought-after professionals, having a wide-range of skills developed in the ambulance setting. As a result they are increasingly work in different sectors such as primary care and emergency departments. We need a future strategy and workforce plan that supports appropriate supply needed in different geographies (to meet system UEC strategies) and allows for paramedics (and other HCPs) to undertake portfolio working opportunities within the local system, without depleting the ambulance workforce; plus better arrangements for rotational roles in Primary Care (see point 2.9).

2.18 **Non-Emergency Patient Transport Services (NEPTS)** and other specialised transfer services (e.g. Neonatal, Adult Critical Care) have a key role to play in keeping patients flowing through systems, in/out of hospital and this can be achieved more effectively and efficiently if those services are coordinated by the respective ambulance service across their regions (as worked well during the pandemic). A refreshed look at commissioning of these services, to include potential for NEPTS to provide intermediate care transport for Cat 3 patients who may require same day hospital services, but do not need to go to ED or to be admitted, could free up or replace double-crewed emergency ambulance resources. For example, a head injury in a patient who is frail, elderly and has fallen over, if triaged would meet the criteria for ambulance to ED (likely a Cat 3), where they will sit on a trolley for ages waiting for a CT scan. If, instead, you consider a virtual head injury pathway, the patient could be triaged by a senior decision maker, arrange transport for the patient to go in (and out) for imaging, with results reviewed by the virtual MDT in SPOA. Most patients will just return home or to their care home. Some may need admission. But the blocker to hospital services accepting referrals in this way is the "emergency patient" being left in their department, so getting them to agree to change the model relies of making sure patients don't end up waiting unnecessarily in their departments.

2.19 **More step-down care facilities and virtual ward teams:** supporting discharge from hospitals / rehabilitation processes, especially for frail/elderly before and after returning home.

2.20 **Paramedics need more widespread recognition as trusted assessors.** For example, a paramedic attends an older person who is frail and has fallen and wants to refer them into appropriate health or social care service to set up packages of care so the patient can remain safely at home. As a trusted assessor they can do this autonomously, without having to refer back to primary care, which leads to delays and repetition of case etc.

**Q3** **What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?**

## Challenges:

3.1 **Securing investment:** always difficult for ambulance services when seeking to update digital solutions and introduce innovation (for both capital and revenue to sustain).

3.2 **Lack of interoperability, standardisation and information governance (IG) gaps:** fragmented systems and IG complexity hinder seamless sharing of health records and integration of care across providers in UEC, adversely affecting patient experience and outcomes.

3.3 **Lack of technological expert capacity:** to allow 'headspace' for researching, developing and introducing strategic innovations. Day-to-day focus is on immediate operational technical issues that need solving.

3.4 **Connectivity:** this can be challenging in some parts of the country for a mobile healthcare provider.

3.5 **Digital literacy and accessibility:** varying levels of digital literacy (and scepticism) among patients and providers may hinder technology adoption – need to ensure solutions are inclusive.

3.6 **Metrics to evaluate impact:** gaining agreement about meaningful metrics (currently "what gets measured gets done" but isn't always related to provision of high quality / equitable care) – how do we know when we are making a positive difference?

## Enablers:

3.7 **Reverse-engineering:** focus on desired / priority patient outcomes and work back from these to harness appropriate technology and digital solutions to support these.

3.8 **Predictive analysis to mitigate risks:** as patients present to the system, AI could have a role in advising the likelihood of serious illness based on demographic, postcode, existing medical records etc.

3.9 **Digital Referral Systems:** the ability to utilise electronic referrals to seamlessly connect patients to primary and community services.

3.10 **Data Sharing & Data-Driven Insights:** leverage AI and analytics, alongside improved IG to support data sharing. Enabling improved operational efficiency, quality through clinical supervision, optimised resource allocation & demand predictions.

3.11 **Expand Remote Monitoring Tools:** more use of digital monitoring / telehealth to keep patients at home.

3.12 **Standardised used of GoodSAM:** to support proactive care and reduce unnecessary ambulance dispatches and ED visits.

3.13 **National/regional/system-based digital 'think-tanks':** rather than organisations working in silos to find solutions to their 'part of the problem'/pathway.

3.14 **Standardisation and shared investment and procurement:** for joined up innovations and emerging AI solutions and advanced digital tools.

3.15 **Enhanced Data Use:** Leveraging ambulance service data to identify health trends and inequalities will support targeted interventions and identify gaps in health /support services.

3.16 **Patient-Centred Design:** engaging patients in the development of service models/pathways, including use of digital tools can improve adoption and user experience e.g. engaging with rough sleepers (YAS), sickle-cell patients (LAS).

3.17 **Expanding the digital infrastructure in ambulance sector** to support advanced practitioner roles will mean more patients can be appropriately treated, monitored, and cared for out of hospital, especially older people and those living with frailty.

**Q4** **What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?**

## Challenges:

4.1 **Ambulance data has historically been chronically underutilised by the public health system,** mainly due to lack of access and issues with consistency and data quality. For example, ambulance data for mental health calls to 999 potentially highlight unmet need and a gap in services for young, deprived patients, in the transition from child to adult services. This data is not included in national analyses for Mental Health care provision.

In order for the Ambulance Data Set (ADS) to be shared with the Office for Health Improvement and Disparities and local authorities, it needs to be approved to be provided through NHS England's Data Access Request Service (DARS). It is on a list to be considered in the next financial year, but timescales are not definite, and it could take up to a further 6 months for the data sharing arrangements to be approved to gain access once available through DARS.

4.2 **System solutions needed for under-served communities and minoritised groups** to reduce inequalities in access to healthcare and outcomes e.g. for rough sleepers, and maternal and neonatal care for Black, Asian and minority ethnic women and babies (see NHS Race & Health Observatory – actions to tackle race disparities in health).

4.3 **Lack of commissioning of prevention activities** is missing the opportunity to exploit the millions of daily contacts the ambulance sector has (both scheduled and unscheduled) seeing and reviewing patients in their home environment where ambulance clinicians can observe, report and advise on wider determinants of health and upstream interventions.

4.4 **Social determinants of health:** factors such as income inequality, housing quality, education/life skills and employment status contribute significantly to health disparities. There is insufficient cross-governmental linkage and appreciation of departmental strategic objectives and priorities as they impact on health and wellbeing.

4.5 **Access to employment:** need for opportunities across all parts of the country.

4.6 **Access to preventive services:** inequitable access to preventive healthcare, especially in socioeconomically disadvantaged communities, limits early illness detection and interventions (e.g. Out of Hospital Cardiac Arrest project highlights higher rates of OHCA associated with lower socio-economic status, lower income, and lower educations levels and in areas with higher proportions of non-white ethnicity).

4.7 **Metrics used to measure ambulance service performance** conflict with their transformational role in reducing health inequalities and improving health.

## Enablers:

4.8 **Greater analysis of ambulance data, through a public health lens.** Ambulance services are almost unique in the UK health system in that they treat patients in their own homes, and in the places in which injuries or ill health affect people most urgently. This means that the ambulance services see patient groups which are under-served by other parts of the health system and may be in a unique position to understand their health needs. This is particularly true of inclusion groups. Ambulance data also holds valuable information on public health issues where patients may not for various reasons access other forms of healthcare such as calls for violence, mental health, drugs or homelessness. Ambulance data is also unique in health data in that it holds data on where the incident occurred as opposed to where the patient lives, so for identifying hotspot locations of incidents or targeting interventions this data may hold huge value. The introduction of the Ambulance Data Set, which aims to provide an improved and consistent level of detail on ambulance activity, should be a significant opportunity for public health to engage with this data and use it to further understand significant public health issues. It can help identify how and where we prioritise initiatives and services to have the biggest impact for our most vulnerable patients and reduce health inequalities. It can also act as early warning intelligence for systems.

4.9 **Identification of personal need:** ambulance services now provide the largest number of assessments in patients home environments and witness the underlying issues that determine health from poor housing, through poverty to loneliness.

4.10 **Public health capacity building:** empowering ambulance staff with public health training will help them contribute to preventive and community-based care, enhancing local health literacy and access to services.

4.11 **Ability to flag/report signs of risks** that are contributing to poor health – air quality issues, poor housing, tripping hazards etc.

4.12 **Community engagement and outreach Public Education:** ambulance services, through their unique reach, and volunteering roles, can be a vehicle for local health education (e.g. CPR training in schools) and outreach, raising awareness of preventive services (e.g. signposting to alcohol support services, social prescribing opportunities). Community first responders and the community welfare responder model (WAST) are great examples of volunteering supporting patients to stay at home.

4.13 **Enhance access to ethnicity data** through the NHS spine across all sectors to improve equity of care for patients from all ethnic backgrounds.

4.14 **Near patient testing:** Research the potential for extending skill-sets for ambulance clinicians to undertake these activities, plus enhance abilities for ambulance clinicians to act on incidental findings of chronic illnesses/diseases e.g. NWAS work on hypertension identification.

**Q5** **Please use this box to share specific policy ideas for change.**

## Short-term (next 12-18 months):

i. Review Ambulance Response Programme (ARP) categorisation, learning from Cat2 segmentation processes, so that we can ensure the sickest patients with time-critical conditions, receive an ambulance response in the clinically required time.

ii. Introduce more appropriate commissioning arrangements (including capital allocations) for ambulance services, including longer-term contracting for 111 and NEPTS services.

iii. Social care workforce capacity and service availability need addressing urgently if the NHS is to function effectively. It is an essential element of care and will be increasingly needed with the predicted demographic changes for an ageing population. Impacting on ability to discharge patients from hospital, and keeping patients out of hospital, safe at home, the presence of reliable, high quality social care is fundamental to enabling the NHS to recover.

iv. More dedicated funding is needed for hospices and community end-of-life care teams.

v. Extend services for out-of-hours mental health crisis teams, non-injurious falls responses and urgent community response teams.

vi. Longer term financial settlements to allow greater ability for ICBs to invest for transformation and for NHS Providers to plan for sustainable and improved services.

vii. A fairer way of addressing capital allocations – again on a multi-year basis.

## Medium term (2-5 years):

viii. Establish regional provision of NHS111 contracts and ICS level Clinical Assessment Services linked to ambulance-led, multi-disciplinary care-coordination hubs, for the reasons outlined in 1.2.

## Longer-term (5-10 years):

ix. Bring NHS 111 into the NHS to be provided by ambulance services – would require changes in legislation and has been put in the ‘too difficult’ box, but this would remove the complications and inefficiencies of multiple 111 providers, variation and inequities in provision, and repeated, inefficient tendering/contracting rounds.

x. Likewise, bringing NEPTS back into the NHS would better support an integrated transport platform across regions, delivering efficiencies, improving flow across systems and more patient-centred care. While this would challenge the thinking that the private sector is cheaper and delivers better quality, NEPTS is another silo, which needs to be addressed if we are going to achieve effective integration of services.