University of Sheffield

NIHR | Health Determinants Research Collaboration Doncaster

Evaluating the implementation of a national consensus statement to strengthen the role of the Ambulance Sector in reducing health inequalities

Annette Haywood; Cara Pippa Kang; Susan Hampshaw

19th March 2025

Background and evaluation aim

- Consensus statement launched in June 2023
- Online webinar prior to the launch
- Two implementation webinars in October 2023 and March 2024

Evaluation Aim:

To evaluate the implementation of a national consensus statement to strengthen the role of the ambulance sector in reducing health inequalities.

Methodology

- Sites were selected from Maturity Matrix (9/13 sites)
- Interviews conducted May to June 2024
- Online interviews up to 60 minutes in duration with staff in senior roles
- Recorded on the secure Teams platform and deleted following analysis (auto transcribed)
- Ethical and governance approvals were obtained
- Data analysed using Framework Analysis (Ritchie et al., 2013)

Staff in senior roles were approached

Chief Executive Chair of Executive Group	
Director/Deputy Director	Strategy and Transformation Partnerships and Operations Operations Human Resources Finance Quality, Information Governance and Risk Medical Leadership and Organisational Development
Leads	Public Health Health Inequalities Digital

Results

- Two sites participated in the evaluation
- Both sites were classed as ‘emerging’ in their organisational level of maturity
- We undertook 7 qualitative interviews with senior staff across the two sites

Awareness of the consensus statement

Some were very aware, stating it informed their work:

> *'I'm very much aware of it, very aligned to it. Almost I feel like I've got the ability to create and show evidence of where we are positive and where we're not so positive.' (Int 7, p8)*

To a more limited awareness:

> *'I remember sort of glancing at it and thinking, oh, that's interesting. So was aware of it. But not in any active or proactive way to think. Now I've seen it. We need to do something about it.' (Int 6, p6)*

To no awareness:

> *'The actual consensus statement is not something that I would … if you'd not mentioned it to me, then I'm not sure I would have recalled that there was one.' (Int 2, p6)*

Launch and implementation webinars

Those who attended were motivated to learn more about the consensus statement:

> *'I joined the launch event … and the kick off event …I was really curious, to be honest. I wanted to get in there quite early to actually understand what it was going to mean and where we were going to go. So for me it was about being curious because it was going to hit my desk very quickly, so that was why I was kind of keen to get in at the beginning.'* (Int 7, p10-11)

Others were unaware of the events:

> *'I've just done a quick search in my emails around health inequalities, webinars and nothing has come up.' (Int 2, p7)*

Maturity Matrix

A variety of opinions:

> *'It shows you really clearly what we're doing well and where we're not doing so well and where we might be able to do incremental changes and actually make a bigger difference.'* (Int 1, p33)

Although there is a potential to use the tool as a way of benchmarking services:

> '*I think (redacted) as an organisation will come up badly on that audit. I don't know how we'll compare to other ambulance trusts… I don't think we did very well.'* (Int 6, p20)

Maturity Matrix

Some questioned its validity and usability:

> *'I was slightly cautious of tools like this as to how useful they actually are. Have we properly tested its validity and things like that?'* (Int 3, p15)

> '*Some more detailed understanding about how to use it and understand the results it was giving us.'* (Int 7, p26)

Understanding of the consensus statement

Some were very clear on the aims and objectives:

> *'Reducing health inequality is in terms of patient access, patient experience and outcomes. And also reducing health inequalities through using (redacted) resources to influence the social determinants of health, and particularly our role as an anchor institution.'* (Int 4, p7).

Others had less understanding due to lack of awareness or misconceptions.

Unique role of ambulance service to '*observe and potentially contribute around eradicating health inequalities'* was highlighted:

> *'it sort of enters patients' lives really quite unique points I think from need. And I think that offers us quite a unique insight into the wider health inequalities as well, and we get to see their homes, how they live, we get to see the communities, what they live in.'* (Int 5, p4-5).

Health inequalities training

Several reported no training on health inequalities with the ambulance service.

One attended a training session on the Core20PLUS5 approach, for another it had been part of other elements of CPD.

During the evaluation a national AACE health inequalities board development session was attended by one of the interviewees.

Health inequalities training suggestions

In person, online or bite-sized videos preferred formats; many disliked e-learning:

> '*staff are fed up with those…the extent to which people actually take in that learning as well is really debatable'* (Int 2, p17).

Many commented that training needed to be engaging or interactive e.g. using lived experience, storytelling and scenarios:

> '*online based training with breakouts and scenario planning would be most helpful rather than just listening to slides or slides being presented, let's say with a voiceover. I think if you're part of it, it makes it …a much more richer and a better learning experience.'* (Int 7, p13)

Health inequalities training suggestions and barriers

Training materials should be ambulance sector specific:

> *'we get a lot of the national products that are very NHS blue and all the imagery is all nursing, midwifery, hospitals, acutes … so staff get really turned off by that because they're just not seeing it in the context in which they operate.'* (Int 2, p19).

Debatable whether health inequalities training should be standalone or embedded.

Barriers included competing training needs, time for non-corporate staff, long time frames for introducing new training.

Impact of the consensus statement

Important for raising the profile of health inequalities:

> *'What it's allowed us to do…it's almost like legitimise it or at least raise its profile in the trust and it's allowed us to move forward with getting access to the board to talk about health inequalities. Which I think has been useful. Whether it's not just a single voice in the trust saying we need to talk about health inequalities, this is now coming down as a consensus that we have come together as ambulance services.'* (Int 3, p7)

> '*It's really changed my thinking cause I think without it, we wouldn't be talking about it… I was quite sceptical when I first saw it and then the more I've come to understand it and the more people are talking about, the more important I think about it…So I think the consensus statement has raised the profile of it and said actually no, this is important in the ambulance sector… it's opened my eyes to what we could do differently.'* (Int 6, p17)

Impact of the consensus statement

Work to address health inequalities noted to be in early stages:

> *'I still think we're at the point where there's …pockets of good practice and there's more that we could do as a sector to learn from each other.'* (Int 1, p28)

> '*I don't think we're anywhere near it yet, though I think we've just started to realise our potential in this area, our potential to help.'* (Int 5, p5)

> *'I suspect it's going to take us longer in the ambulance sector than the rest of the NHS to address this, I think we're really bad at public health, not deliberately bad at public health, it's just it's never featured on the agenda.'* (Int 6, p10)

Impact: Service design and delivery and Core20PLUS5 approach

No changes to service design and delivery:

> *'we're at our very earliest thinking about analysing our data and acting on what the data tells us about our population and how we then deliver services differently to those different patient groups.'* (Int 6, p9)

Examples of work to address health inequalities preceding consensus statement:

- An engagement project to better understand experiences of an inclusion group to inform service delivery.
- Initiatives to target two groups from the Core20PLUS5 approach.
- Using the Core20PLUS to *' look at where we want to focus our attention. We've also used it to develop and start to test ambulance health inequalities indicators to start to develop a dashboard for us.'* (Int 3, p12)

Impact: Service design and delivery and Core20PLUS5 approach

Importance of data and analysis to inform service design:

> *'So the Core20PLUS5 approach is really good for helping us identify which populations we might want to target. So you know, people living in areas of deprivation, inclusion health groups and others. That's fine, but if we don't have the data or the analysis that helps us look at real service usage from those populations it's still helpful, but it's less helpful because we can't understand what's happening from an ambulance sector perspective.'*
> (Int 1, p24)

Impact: Collaboration

Examples of collaboration between departments to work on the health inequalities agenda:

> *'the medical team and nursing and quality team are working together on public health…we have a sort of link with the estates and fleet team, the fleet is where our new green vehicles are coming from… bringing teams together to work on the agenda.'* (Int 6, p30)

> *'At the moment, that's very much led by where there are volunteers that want to work; rather than led by patients' need is led by volunteer. And actually we're providing data to that team. So these are the gaps where you might want to go and actively recruit volunteers to fill those gaps in response in the most deprived areas where there are less volunteers.'* (Int 3, p16)

Impact: Recruitment practices and roles

No changes to recruitment practices or positions as a result of consensus statement.

Gaps in public health expertise and difficulty getting substantive funded posts.

Motivation to recruit public health specialist staff:

> *'we're really quite keen internally to recruit and retain …a health analyst because we're data rich information poor.'* (Int 5, p5)

Impact: Recruitment practices and roles

Data used to identify lack of diversity and inform ongoing work on inclusive recruitment:

> *'our latest datasets are still telling us you're twice as likely to get recruited if you're white.' (*Int 2, p11)

Challenges of changing established recruitment practices such as deviating from using NHS jobs noted.

Some commented no progress towards anchor institution goals; aspirations towards this:

> '*we could establish a satellite call centre in one of the more deprived communities… which would help with …social determinants of health…This would give more job opportunities to people in those communities.'* (Int 4, p13).

Prioritisation

Some strategic prioritisation of health inequalities:

> *'It's in our strategy. I wouldn't say it's in our business plans. And that's the difference between a talking shop and doing something about it… we've put together a business plan for the year and that didn't get accepted or funded... that's the problem' (*Int 3, p10-11)

In board business plan awaiting commissioners' approval in one Trust and two health inequalities objectives in quality account.

Board support developing, potential to use data and patient stories to persuade boards to focus on health inequalities.

Prioritisation

Competing priorities identified as a key barrier:

> *'Absolutely agree it's priority. But then my pushback is where does it sit in all the other priorities? Then, when we're going to category 1 calls, so there's something around that. So I do wonder if sometimes there isn't a rub, a pressure between the different priorities and I think that's something to work through and even out.'* (Int 5, p11)

> '*If I ask the frontline paramedic…whether they would think it's a priority for us when we don't get to our patients on time… I wonder whether they would say look let's make sure we provide an ambulance to sick people quickly as our sort of overall top thing and once we get that cracked then we can start to tailor our care to the different groups.'* (Int 6, p18)

Accountability

Influence of NHS and government on board priorities through measurable ambulance response time targets:

> *'There is a unilateral focus on providing quick answers to problems or quick solutions to problems including things like category 2 performance rather than longer term views and planning…some of that's NHS performance, NHS financing, it's all about what you can do within year. You can't do that longer term planning …that's a barrier to doing things like health inequalities because it's all about what we can do this year and what we can achieve and reduce and measure within one year…That's the NHS and that's the way the Treasury works unfortunately.'* (Int 3, p16-17)

Focus on response times criticised:

> *'it's the easy measure and it's the easy measure to be held accountable to. And sometimes you know, it doesn't always tell you about that patient experience or that outcome or… the predictive bit and the wider health inequalities conversation.'* (Int 5, p9)

Accountability

Lack of targets from NHS England and the government a key barrier:

> *'Until the government, via NHS England, starts setting tangible objectives and measuring the success of provider organisations like (redacted ambulance service name) or like an acute hospital or whatever on health inequalities, then it is difficult when you've got very stretched resources to give it the priority it deserves.' (*Int 4, p18-19)

Some thought targets should be set by commissioners:

> *'the role of the ICBs in mandating a system approach to tackling health inequalities would be helpful… So I think there is something that they need to think about making or mandating or providing the push for organisations to take this on now and prioritise and put it higher up in the priorities.'* (Int 3, p19)

Responsibility

Health inequalities important part of senior leaders' personal roles:

> '*I see it's one of my moral things I need to work through.'* (Int 7, p8)

Reliance on colleagues with public health expertise to drive health inequalities agenda and concern that responsibility not embedded across the service:

> *'we need that kind of real understanding across the organisation of what it means, you know, top to bottom, so that it just becomes embedded in part of everything that we do and actually in all of our conversations, we're saying, well, what might that do to reduce health inequalities? Is it likely to make health inequalities worse?'* (Int 1, p29)

Funding

Many commented about financial constraints:

> *'The only areas where I see any cause of concern is around the financial can we afford to do it? And if we do this, what else don't we do? What do we stop?* (Int 7, p23)

No additional funding at Trust level to implement the consensus statement, more funds needed:

> **'***There's always money. Money talks… actually ring fence money to do something about it rather than... just expecting organisations to pick up this work and try and do something about it.'* (Int 3, p19)

Need for stakeholder engagement and collaboration

Many actions to reduce health inequalities outside the ambulance service's remit:

> *'I think the ambulance service generally picks up the pieces for health inequalities. Whether that… be right from the social determinants leading to crisis, but then also access issues in other parts of the NHS, so like primary care like mental health, and we just see it all coming through as a crisis that we have to deal with and we have to put solutions in to manage that demand.'* (Int 3, p22)

Lack of understanding by stakeholders in the NHS about the ambulance service's role:

> *'one of the things that I think is there in the consensus statement that perhaps needs to be amplified is the huge additional role that the ambulance sector can provide, which is poorly understood by the rest of the NHS, through the immensely rich data that we have because of the way we work through our call centres, what our crews see in people's homes'* (Int 4, p8)

Need for stakeholder engagement and collaboration

Stakeholder engagement viewed as important to facilitate collaboration :

> *'most of what we would need to do to address health inequalities, we have to do in collaboration with others so you know, we have to build those alliances around particular things, and that takes time, and it obviously takes a work, takes a willingness from the other parties to do that.'* (Int 4, p28)

Collaboration with ICBs to work on health inequalities agenda seen as challenging due to:

- ambulance services crossing multiple ICB areas
- variations across ICBs in their progress on work to tackle health inequalities

Limitations of the evaluation

- 9/13 services had completed the Maturity Matrix by April 2024
- English ambulance services targeted so less applicable to devolved nations
- Only a small number of senior staff participated
- Impact focussed on senior leadership roles and thinking

Recommendations

1. **Raise the profile of the national consensus statement to ensure awareness amongst senior roles:**
    - Further implementation webinars with targeted invitations to all senior leadership.
    - Board development session at individual ambulance services on health inequalities.

Recommendations

2. Regular health inequalities training for all ambulance service staff:

- Covering the ambulance sector's role in reducing health inequalities and individual roles and responsibilities.
- Training in person or online, avoid e-learning.
- Interactive training sessions.
- Inclusion of lived experiences and storytelling to help with engagement.
- Ambulance sector specific training materials.
- Protected time for training.

Recommendations

3. Resources and support for reducing health inequalities:

- Internal links on every ambulance service's website to the national consensus statement, launch and implementation webinars and resources.
- Health inequalities champion in each Trust to help signpost colleagues to resources and support.

Recommendations

4. Public health expertise:

- Establish funded public health lead role and public health data analyst within each ambulance service.
- Establish links with Postgraduate Schools of Public Health to facilitate Public Health Specialty Registrar placements with ambulance services.

Recommendations

5. Further engagement by individual ambulance services and AACE with stakeholders (ICBs/commissioners/NHS England/Government/Department of Health and Social Care) about:

- The ambulance sector's role in reducing health inequalities.
- Working collaboratively to address health inequalities.
- Dedicated funding for the ambulance sector's work to reduce health inequalities.
- How to create accountability for health inequalities and whether targets are needed.

Recommendations

6. Future evaluation:

- Targeted training to include how to use the Maturity Matrix and how to interpret the results.
- Maturity Matrix to be completed on an annual basis and used by ambulance services to self-evaluate progress on enablers to reduce health inequalities.
- Further evaluation to include views of frontline staff.

Our contact details

Annette.Haywood@sheffield.ac.uk
Susan.Hampshaw@doncaster.gov.uk
cara.kang@nhs.net (Pippa)