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NHS England

2026/27 ambulance emergency and urgent care service specification

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Contents

Service Specification No.	
Service	2026/27 Ambulance emergency and urgent care service specification
Commissioner lead	
Provider lead	
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1. Introduction

The purpose of the ambulance emergency and urgent care service specification (the specification) is to set out the expectations for ambulance services in 2026/27. The specification has been designed for use by ambulance services and commissioners when commissioning the regional ambulance service. The specification is a one-year specification and will be subject to review during 2026. The service specification is **not:**

- a workforce planning strategy for the ambulance sector
- a transformation or reform strategy
- a vehicle for introducing new financial mechanisms
- an opportunity to request additional resources
- a mandate for adding new functions to the ambulance service

The ambulance service is a statutory provider and is an important health resource for the population. For many people who dial 999, the ambulance service is often the first point of access to health care. The core function of the ambulance service is to provide an emergency response to those patients who have a life-threatening emergency and respond to major incidents. Ambulance services will also provide support to patients with urgent care needs, which may include directing them to a service that can best meet their needs.

NHS ambulance services are supporting the ‘left shift’ agenda; moving care closer to home, working within more joined up, person centred care in the community and reducing reliance on acute care. Ambulance services have supported 45.9%[1] of patients who have called 999 to be cared for at home, or within the community, because of the transformation and

[1] Ambulance Quality Indicators – between April and August 2025

improvements they have delivered. This is a 1.2% improvement on the same period last year.

The redesign of Urgent & Emergency Care (UEC) services, in line with the 10 Year Health Plan, will strengthen and improve alternative care pathways so that care is delivered closer to home, and conveyances to hospital, attendances and admissions are reduced:

- For those people with urgent but non-life-threatening needs, the provider will deliver a highly responsive, effective and personalised service outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.
- Those people with more serious or life-threatening emergency needs should be attended in the pre-hospital phase by the appropriate level of expertise with the required equipment, to maximise their chances of survival and a good recovery.
- People requiring transportation will be conveyed to the closest most appropriate centre with the relevant and required expertise. It is recognised that there may be a requirement to bypass geographically closer, but less appropriate facilities, to meet the clinical needs of the patient, minimise the need for secondary onward transfer and reduce the time to definitive care.

2. Scope

This specification applies to all NHS funded ambulance services in England, including the Isle of Wight. It covers:

- 999 call handling
- emergency and urgent 999 response
- major incident and resilience capability

This specification outlines the commissioning requirements for ambulance services in England, including the Isle of Wight, and is designed to:

- reduce unwarranted variation
- ensure consistency, quality, responsiveness and integration with the broader urgent and emergency care system
- enhance decision making capacity and capability at a local level

While important for overall delivery, NHS 111, hazardous area response (HART), specialist operations response (SORT), non-emergency patient transport services and air ambulance provision are out of scope of this service specification.

Unless stipulated within this specification, all other journey types will be excluded and subject to local determination; for example, repatriation.

3. Strategic objectives

To support the 10 Year Health Plan and Urgent and Emergency Care Plan 2025, the strategic objectives for ambulance services in 2026/27 are:

- to provide a safe, efficient and effective emergency and urgent care ambulance service for patients, while being responsive to local needs and priorities
- to deliver core response functions as included in the ambulance quality indicators and clinical quality indicators, and improve outcomes through clinically appropriate triage, treatment and conveyance
- to continue to expand proven remote clinical models of care and navigation for urgent patients, enabling more precise rapid targeting of ambulance resource to the sickest patients through:
    a. improving response times for life threatening and emergency incidents, including reducing time on scene for patients where this will lead to improved outcomes
    b. increasing the percentage of eligible calls managed through ‘hear and treat / refer’ and ‘see and treat / refer’ options including into non-ED and community services where appropriate, either directly or through single points of access (SPoAs)
    c. working with system partners to develop urgent care capacity, with paramedics as integral or rotating members of community multidisciplinary teams
- work with system partners to maximise the use of clinical resource, ensuring, wherever possible, patients are only clinically assessed once to avoid duplication and improve patient experience
- expand overnight support for 999 call handlers and clinicians to provide urgent remote in-home care for clinically assessed patients, with follow-up services available the next day
- streamline access into alternative urgent care providers and support ‘left shift’ from acute settings

    - The provider should review calls and refer patients into community services at the earliest stage possible to support a safe reduction in ambulance dispatch and conveyance to ED
- enhance and expand paramedic-led care in the community so more patients receive effective treatment at the scene or in their own homes, reducing avoidable hospital conveyance
- implement ‘call before convey’ principles, ensuring paramedics can access senior multidisciplinary decision-making support, for shared decision making, at the scene, either through emergency operating centres (EOCs) or SPoA
- improve culture through implementing the recommendations of the ambulance culture review
- support delivery of integrated care systems (ICSs) and neighbourhood health priorities and enhance integration with primary care, mental health and community services
- work with system partners to strengthen consistent access to alternative provision including same day emergency care (SDEC) and urgent community response (UCR), supported by trusted assessor principles
- fulfil statutory duties and comply with national standards relating to emergency preparedness, resilience and response (EPRR)
- effectively use ambulance volunteer responders such as community first responders (CFRs) in addition to the trust’s statutory response for the delivery of both emergency and urgent care

There must be equitable service provision between patients presenting with physical and mental health needs. Services must also take proactive steps to ensure equitable access for all patients, including those from marginalised or underserved groups, to reduce health inequalities.

All parts of the NHS have a role to play in addressing equality and health inequalities to create high quality care for all, as commissioners or providers, as employers and as local and national system leaders. ICBs and ambulance services should use the Health Inequalities and Equality Legal Duties document published by NHS England to inform action to meet their legal duties on health inequalities and equalities

4. Population needs

11 NHS ambulance services provide emergency and urgent care services for the (approx) 57 million people in England (including Isle of Wight), a population that is ageing and where an increasing proportion of people live with multi-morbidity. Demand for NHS ambulance services has grown consistently over the past 15 years and is expected to continue to increase. This includes proportionally greater demand from higher acuity and emergency (that is, Category 1) incidents as people living with long-term major conditions experience deteriorations in their health, which result in them requiring a more rapid ambulance response.

NHS ambulance services in England provide over 9 million episodes of care each year, for both physical and mental health conditions, for patients either resident in, or travelling through, the regional footprint of an NHS ambulance service. Demand from less urgent presentations is also increasing.

As NHS ambulance services deliver care across the broadest range of the population, they play a key role in population and public health improvement. Providing high quality clinical care to address the presenting needs of each patient, NHS ambulance services are uniquely placed to support health and wellbeing improvements across communities and reduce health inequalities through targeted interventions, including through prevention approaches.

4.1 Local population needs

[ICB to add breakdown of population demographics and geography including protected characteristics].

5. NHS outcomes and oversight frameworks

5.1 NHS outcomes framework

The NHS outcomes framework (NHS OF) indicators provide national level accountability for the outcomes the NHS delivers.

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environments and protecting them from avoidable harm

The provision of a high-performing, safe and effective NHS ambulance service can be mapped to the domains within the NHS outcomes framework.

5.2 NHS oversight framework

The NHS oversight framework was published in June 2025. It sets out how NHS England will oversee the performance of integrated care boards (ICBs) and trusts in 2025/26 including a process of segmenting each NHS trust into one of four categories based on their relative level of challenge. Segmentation is determined through performance against a range of metrics which cover 5 major domains:

Domain 1	Access to services
Domain 2	Effectiveness and experience of care
Domain 3	Patient safety
Domain 4	People and workforce
Domain 5	Finance and productivity

Each domain contains a range of metrics applicable to different trust types. Overall segmentation is determined by taking each trust's average metric score, which is then quartiled against the average score of every other trust to produce a final segment. Segmentation indicates the breadth of areas in which each organisation may be challenged but there is no single uniform response to segmentation. NHS England will review the segmentation outcome alongside other key data, such as perceptions of each trust's capability to improve, to determine where further interventions, support or enforcement action may be appropriate or where additional freedoms could be provided.

Overall segmentation determines where major cross-cutting support such as the Recovery Support Programme is deployed but individual programme-level support offers will align with individual domains/metrics as they have a narrow locus of focus.

6. Service delivery

6.1 Ambulance constitutional standards

There are 4 999 call categories within the NHS Constitution. These categories ensure the sickest patients get the fastest response and are prioritised in a way that increases the chance of survival, reduces suffering, and optimises a good recovery outcome.

NHS ambulance services are measured on the time they take from receiving a 999 call to a vehicle arriving at the patient's location. The categories, which set out mandatory response times across all levels of acuity are shown below.

Category	National standard	
	Mean	90th centile
Category 1	7 minutes	15 minutes
Category 2	18 minutes	40 minutes
Category 3	None	120 minutes
Category 4	None	180 minutes

6.1.1 Ambulance quality indicators (AQIs)

All aspects of NHS ambulance service performance and delivery must be measured accurately and consistently as per the ambulance quality indicators. All details relating to the technical aspects of the standards, indicators and measures, including clock start and clock stop, can be found in the ambulance quality indicators specification.

6.1.2 Clinical quality indicators (CQIs)

The provider should report, and seek to continuously improve, clinical quality indicators as specified by NHS England. This includes performance standards such as those relating to cardiac arrest, STEMI heart attack and falls. All details relating to the technical aspects of these indicators, can be found in the ambulance quality indicators: clinical quality indicators specification and the November 2024 addendum.

6.1.3 Locally defined outcomes

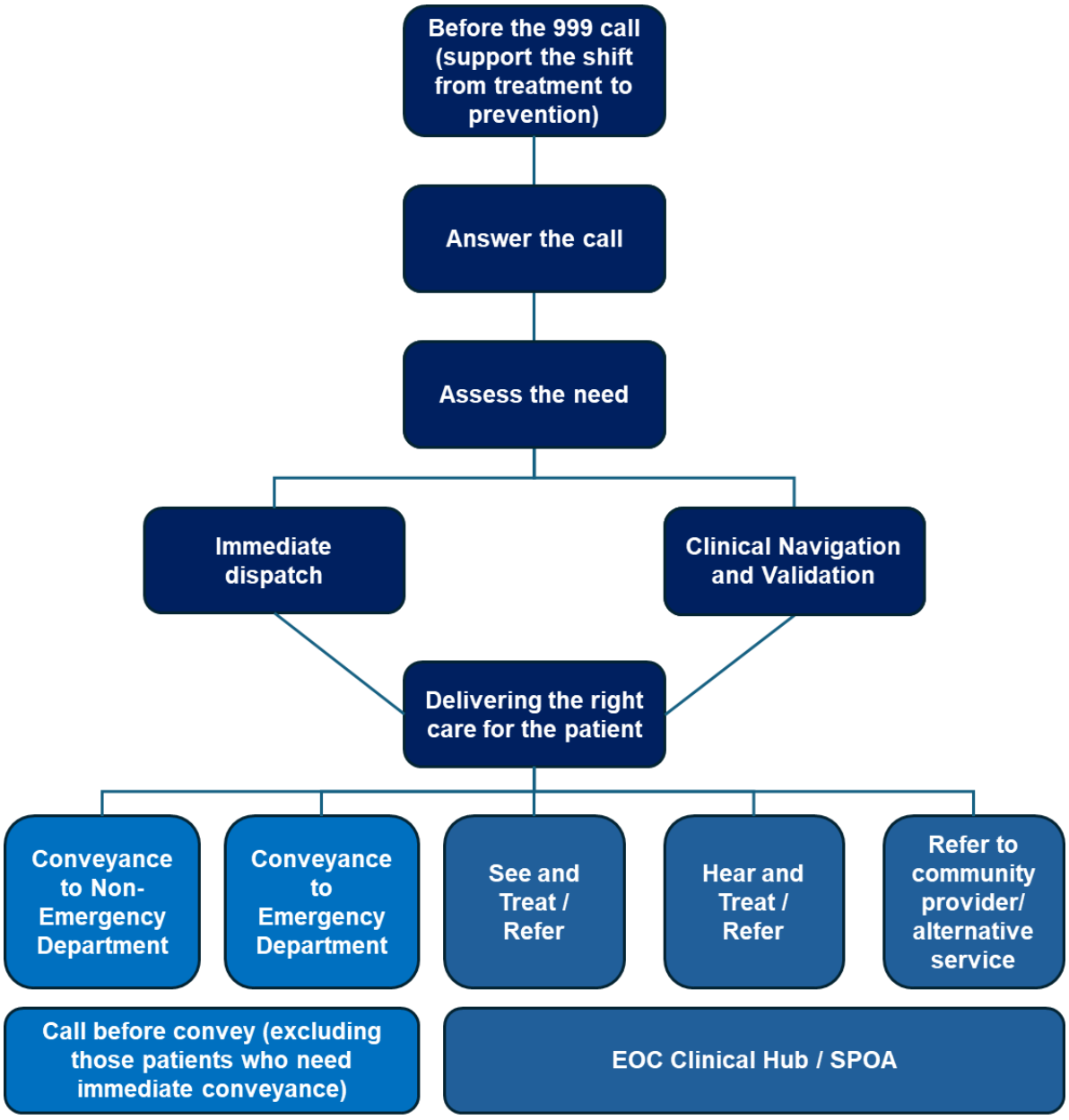
As well as the common set of outcomes above, commissioners may consider and, in agreement with the provider, define additional local outcomes depending on local demographics and population needs.

6.2 Service delivery requirements

The NHS ambulance service is free to the public and is available 24 hours a day, 7 days a week, to respond to the public in a clinically appropriate and proportionate way when they:

- dial 999, or when another service refers the patient to 999 including NHS 111, healthcare professional (HCP) and Police
- require emergency treatment and transportation with serious or life- threatening illness/injury
- present with lower acuity urgent, and less urgent, conditions that require clinical assessment and treatment, transportation or signposting

The provider is required to deliver the following:



The following sections relate to each stage within the diagram and provide a detailed description of each element.

6.2.1 Before the 999 call (support the shift from treatment to prevention)

Within public health a 3-tier model of prevention is often considered, which recognises that there are opportunities to be preventative even after a problem has emerged.

Using the 3-tier model of prevention, the provider will work collaboratively with ICBs, to implement strategies to better manage patient demand and support the shift from treatment to prevention. This will include:

Primary prevention

- Produce an annual action plan with measurable deliverables that support broader social and economic development, reflecting the role of the NHS ambulance services as anchor organisations.

Secondary prevention

- Use a Making Every Contact Count (MECC) approach to support early intervention by signposting and/or referring patients to alternative care pathways where this can reduce the risk of future 999 calls.

Tertiary prevention

- Take a trauma-informed approach to the management of frequent callers and high intensity users, working collaboratively with ICBs and primary care and alongside other services; for example, NHS 111, primary care.
- Establish or maintain mechanisms to share appropriate clinical information with patients' usual care provider to support management of long-term conditions (for example, referrals for patients with diabetes, substance misuse or falls, or automated messaging to registered GP practices).

To support implementation of the above, ambulance services should:

- develop and embed public health leadership within their organisations
    - including having a board level executive lead for health inequalities who will provide strategic oversight of organisational health inequalities work and encourage other executive board members to embed an equity lens to their work programmes
- in collaboration with ICBs, use ambulance data effectively to identify and improve health inequalities
    - this should use NHS ambulance services' rich data, disaggregated by age, sex, deprivation and ethnicity, to identify opportunities and take action to implement culturally appropriate, proactive care models for high-risk populations which optimise patient care and system performance and reduce health inequalities
- produce an annual health inequalities report and/or update for the board
    - this should report on specific actions taken to support the shift from treatment to prevention and reduce health inequalities including assessment of impact

- enable access to health inequalities training, education and support
    - the provider should embed the principles of health inequalities within mandatory training programmes and offer education and support that is tailored to staff and volunteer skill mix
    - these should be specifically designed to equip ambulance staff with the skills to recognise and respond effectively to diverse cultural needs, while understanding how professional attitudes and behaviours significantly influence patient experience and safety

6.2.2 Answer the call

The provider is required to:

- provide a 999-call triage service 24 hours a day, 7 days a week
- answer the incoming call without delay
- prioritise 999 calls

The provider is required to assess and triage all calls, using a triage tool accredited for use within England. This includes calls from the public via 999, from other healthcare professionals and other emergency services.

Ambulance calls come from 4 main routes:

- A 999 call for NHS ambulance service assistance by a person who is in the geographical area of the NHS ambulance service, or that is transferred from another ambulance service at times of high demand.
- NHS 111 calls passed to the NHS ambulance service, via an electronic ITK link where this is available.
- A registered HCP for the emergency or urgent transfer of a patient to a healthcare setting on the grounds of an urgent clinical need (including interfacility transfers).
- Police, Fire Service or HM coastguard.

Calls should be answered in line with the operational measure for call handling:

- 10 second mean

The provider is required to prioritise 999 calls into 4 categories:

1. Category 1 – Life threatening
2. Category 2 – Emergency
3. Category 3 – Urgent
4. Category 4 – Less Urgent

These categories aim to ensure the sickest patients get the fastest response and that all patients get the right response first time.

The provider will:

- ensure telephony systems are fully compliant as Category 1 responders under the Civil Contingencies Act including implementation of the minimum requirements set out in Resilient Telecommunications Guidance for NHS England and the NHS in England
- ensure there are sufficiently trained call handlers available to meet forecast demand including predictable surges in 999 calls
- ensure patient triage is undertaken fully by an appropriately trained person, and the required level of quality assurance is undertaken, ensuring the standard of call handling meets the triage tool licensing requirements
- use the NHS England national demand and forecasting planning tool to determine capacity to meet demand, including in periods of surge
- prioritise life-threatening incidents, including those from healthcare professionals, through use of pre-triage questions (PTQ) and the Nature of Call (NoC)
    - the PTQ and the NoC processes have been proven to identify Category 1 incidents at the earliest opportunity and must be used by all NHS ambulance services to improve the speed of response to these patients
    - a national mandated model of PTQ and NoC has been developed and approved by NHS England and should be adhered to by all NHS ambulance services
- ensure the call is documented in the Computer Aided Dispatch (CAD) System, or a paper record if CAD is not available due to technical failure
- work collaboratively with ICBs and primary care to support system level management of frequent callers and high intensity users alongside other services; for example, NHS 111, primary care

- have an approach in place to support national or regional call handling interoperability and resilience including an electronic ITK for transfer of the calls without delay
- clinically navigate and clinically validate appropriate HCP referrals and have clinical conversations with registered HCPs requesting ambulance transport to determine the most appropriate response, which may include an alternative to ambulance dispatch
- transfer patients who, as a result of assessment / diagnosis within a healthcare facility, require immediate life-saving intervention at a specialist healthcare facility
    - the interfacility transfer should be undertaken within a set timeframe mapped to ambulance categories
    - if an ambulance is not immediately available for dispatch this incident should be escalated within the EOC to ensure an appropriate response and maintenance of clinical oversight while waiting for dispatch

An interfacility transfer (IFT) Level 1 or Level 2 incident must be treated the same as any other Category 1 or Category 2 that comes from the community and must not be deprioritised because the patient is in a hospital setting.

- ensure all staff, patients, service users, families and carers have access to information, translation and interpretation services when needed.

6.2.3 Assess the need

Not every patient who calls 999 requires an emergency ambulance dispatch. Through multi-disciplinary partnership working, right-sizing of community capacity and skills, and technological innovation, the provider has an enhanced ability to support the ‘shift left’ from hospitals into the community. This requires support from commissioners and ICBs to ensure there is appropriate capacity in the community.

The provider is required to safely reduce avoidable conveyances to emergency departments (EDs). They will achieve this through increasing ‘hear and treat / refer’, ‘see and treat / refer’ and conveyance to alternative healthcare provision, such as SDEC and urgent treatment centres (UTCs).

To maximise this opportunity, non-ED healthcare services need to embrace the trusted assessor model to avoid delays and facilitate seamless transfers.

Using a triage tool accredited for use within England, all calls will be assessed to determine if they require immediate dispatch or are suitable for clinical navigation and validation.

6.2.4 Immediate dispatch

Through triage, the provider will identify those patients who need an immediate ambulance response – that is, Category 1 and those Category 2 calls identified as requiring immediate dispatch. When an ambulance is not immediately available this will require mechanisms to ensure that ambulances enroute to a lower priority call can be quickly diverted to a higher priority call.

The provider is required to undertake immediate, and necessary interventions to preserve life and support the patient's clinical condition. This will include giving telephone advice to bystanders including basic life support instructions, the collection and use of a public access defibrillator, dispatch of an appropriate resource and deployment of first responders.

The provider should consider the use of video support, in some cases, to support triage and improve the accuracy of the information the emergency call handler can gather.

6.2.5 Clinical navigation and validation

All other calls that do not require an immediate dispatch of an emergency ambulance, as a result of triage, but do require a response to be coordinated, must be clinically navigated and/or validated. Where appropriate, calls that are suitable for clinical navigation and clinical validation, where appropriate, should be protected from dispatch to enable a clinical review or assessment to be undertaken.

Clinical navigation is the rapid clinical review of eligible incidents to determine whether the patient's needs may be better met through clinical validation.

Clinical validation is a timely remote clinical assessment of a patient, by a suitably skilled and experienced clinician, to determine the best response for the patient's immediate needs.

The provider will:

- operate a clinical support hub 24/7 within the EOC. Configuration of the clinical support hub, including collaboration and colocation with the SPOA or other remote clinical workforce (NHS111/CAS), is for local determination
    - the provider should work with system partners to help define and document clear responsibilities between the EOC and SPOA multidisciplinary team (MDT)

- maximise opportunities for clinical navigation and clinical validation ensuring, wherever possible, patients are only clinically assessed once to avoid duplication and improve patient experience
- ensure all clinical decision makers, including those undertaking remote clinical assessment, use a clinical decision support system to aid their decision making and protect patient safety
- provide high quality and safe clinical assessment, via clinical validation, for those calls identified through clinical navigation as suitable for remote clinical assessment
- implement Category 2 streaming as per the national principles
- provide clinical support to emergency resource dispatchers for patients awaiting dispatch
- have access to a SPOA MDT
    - configuration of the clinical support hub, including collaboration and colocation with the SPOA, is for local determination but should align to the principles set out by NHS England
- ensure that any ambulance CFRs dispatched to the scene operate under timely and appropriate remote clinical supervision and decision-making support

6.3 Delivering the right care for the patient

Delivering the right care for the patient is a central pillar of transforming NHS ambulance services within the urgent and emergency care system. The ambition is to ensure patients are seen by the right service, in the right setting, at the right time, and not defaulting to ED when it may not be the right outcome for the patient.

6.3.1 Hear and Treat / Refer

Hear and Treat / Refer is managing patients without a face-to-face ambulance response. It incorporates telephone advice that callers, who do not have a serious or life-threatening condition, receive from an NHS ambulance service after calling 999 or signposting by a non-clinical handler. They may receive advice on how to care for themselves or where they might go to receive appropriate assistance.

Hear and Treat / Refer enables emergency ambulances to be prioritised for the sickest patients. Patients who do not need an ambulance can be referred into alternative services. Hear and Treat / Refer will:

- provide patients with self-care advice for management at home
    - these are dispositions of self-care advice in the NHS Pathways triage system and the omega dispositions in the Advanced Medical Priority Dispatch System (AMPDS) triage system
- refer patients into an alternative service including primary care and/or existing care teams, urgent community care or ED if an on-scene clinical assessment is not required
- re-direct patients for further clinical review or care co-ordination, that is SPOA

The provider will:

- maximise the delivery of Category 2 streaming to ensure maximum opportunity for clinical navigation and clinical validation before dispatch of an ambulance
- have sufficient numbers of EOC clinicians, with the right skill mix and seniority, to achieve the level of clinical navigation and clinical validation required to meet demand.
- encourage multi-disciplinary teams that include nurses and mental health specialists, to broaden the range of patients who they can assess
- based on 2025/26 outturn, safely determine an improvement trajectory for 'Hear and Treat' rates, through clinical validation of eligible Category 2, 3 and 4 calls
    - this should be based on population health data and out of hospital service availability
- following clinical assessment, maximise referrals into alternative healthcare pathways, using the trusted assessor model; this can be supported by the SPoA
- manage lower acuity patients (Category 5)[2] who present overnight and who have been clinically assessed as suitable for an alternative pathway
    - these patients may be suitable to remain in their homes with sufficient clinical oversight, so that they can be booked into an urgent appointment the following morning

[2] Category 5 / Category 5 Signposting represents a clinical recommendation that the call can be closed at call handler level subject to local governance arrangements being in place (incl. appropriate scripts). This includes referral of calls to other appropriate agencies/providers where arrangements exist for either clinical validation and/or a physical response.

6.3.2 See and Treat / Refer

See and Treat/ Refer is where a suitably senior on-scene ambulance clinician, or CFR under remote clinical supervision and decision-making support, assesses the patient and provides treatment at scene, without conveying the patient. See and Treat / Refer will:

- provide patients with self-care advice for management at home
- refer patients to an appropriate service to meet their needs
- re-direct patients for further clinical review or care co-ordination; that is, SPOA

The provider will:

- provide remote or on-scene senior clinical support to ambulance clinicians and CFRs, through attendance of a more senior clinician or through a remote senior decision maker in an EOC clinical hub or access to a SPOA
- use ‘call before convey’ models to support clinical decision-making on scene, identifying alternatives to conveyance and, where appropriate, passing clinical responsibility to a remote clinician; that is, in the SPOA to enable crews to be released
- use approved transport options, where it is safe and appropriate to do so
    - this could include collaboration with locally commissioned taxis, Patient Transport Services (PTS) or volunteer transport to use availability for lower acuity patients and to protect emergency ambulance resource for the sickest patients
    - these services must be risk assessed, and staff will have the appropriate Disclosure and Barring Service (DBS) checks, as well as having reporting mechanisms available
- based on 2025/26 outturn, safely determine an improvement trajectory for See & Treat rates, based on population health data and out of hospital service availability

6.3.3 Refer to community provider / alternative service

As identified through clinical assessment, the NHS ambulance service may not always be the most appropriate service to meet the patients’ needs. For these patients, the provider will maximise the opportunity for patients to be appropriately managed in the community.

The provider will:

- use SPOA as a cornerstone for streaming urgent care pathways and reducing avoidable conveyance
    - there should be clear pathways from NHS ambulance services into each SPOA
- refer into urgent community care including primary care
- provide data to the ICB where there are gaps in community provision to inform future pathway development and commissioning decisions, including overnight demand
- implement trusted assessor models

6.3.4 Conveyance to non-emergency department

Once a decision has been made to convey a patient to definitive care, but determined that ED is not the appropriate destination, the on-scene crews should default to ‘call before convey’ shared decision-making principles to determine the most appropriate pathway for the patient. Call before convey is a mechanism to link an ambulance clinician at scene to additional clinical expertise to make a shared decision on the most appropriate pathway for the patient, sharing risks, and support decision making.

All opportunities should be explored to ensure the most appropriate healthcare setting is identified for the patient and where possible, safely avoiding conveyance to ED.

Conveyance to non-ED includes:

- SDEC
- urgent treatment centres
- direct admission
- other locally agreed pathways

6.3.5 Conveyance to emergency department

Where a patient has been identified as needing an emergency ambulance response, an ambulance should be immediately dispatched and the patient assessed, stabilised and conveyed without delay. This could be to an ED or specialist unit.

For all other patients, the provider will work towards:

- only conveying patients to the ED when a ‘call before convey’ decision determines that ED is the right response for the patient’s needs

- using approved transport options, where it is safe and appropriate to do so
    - this could include collaboration with locally commissioned taxis, PTS or volunteer transport to use availability for lower acuity patients and to protect emergency ambulance resource for the sickest patients
    - these services must be risk-assessed and staff have the appropriate DBS checks, as well as having reporting mechanisms available.

6.3.6 Mental health in urgent and emergency care

NHS ambulance services play a critical role in responding to people in mental health crisis. The provider will ensure that mental health is embedded as a core part of UEC delivery, in line with national policy, the 10 Year Health Plan and best practice. The provider will:

- work in partnership with ICBs, mental health trusts and police services to design and deliver models that are clinically appropriate, person-centred and responsive to local need
    - where possible, service development and evaluation should involve individuals with lived experience of mental health crisis to ensure services are responsive, compassionate and recovery-focused
- fully mobilise mental health response vehicles (MHRVs) where they have been commissioned and delivered, in partnership with ICBs.
    - these joint-response units, typically staffed by a paramedic and mental health professionals are intended to reduce avoidable conveyance to ED, improve patient experience and offer a more appropriate, timely crisis response in the community
- work with system partners to ensure MHRVs are integrated within local care pathways, appropriately funded, and operating to the full extent of their intended use
- embed mental health expertise within EOC, enabling timely clinical advice, triage and support for call handlers
    - this capability should support effective clinical validation, reduce avoidable dispatches and increase opportunities for referral to appropriate mental health services before conveyance is considered
- where appropriate, use technology to enhance access to mental health expertise, including virtual consultations or remote clinical oversight
- contribute to data improvement and transparency by ensuring mental health activity, including that of MHRVs, is recorded accurately and reported via national data sets,

such as the ambulance data set (ADS) and the mental health services data set (MHSDS)
    - where MHRVs are staffed by mental health trust staff, activity should be captured and flowed via the trust to ensure consistency and alignment with national reporting
- ensure local operational protocols reflect these requirements and are agreed jointly with mental health providers and police services, in line with the Mental Health Act Code of Practice and local Right Care, Right Person (RCRP) arrangements
- ensure all frontline and EOC staff receive regular training in mental health awareness, trauma-informed care/practice, and de-escalation
    - staff wellbeing support should also be embedded, recognising the emotional demands of mental health crisis response
- contribute to wider prevention work, through integrating suicide prevention and early intervention approaches into call handling, triage, and on-scene care
    - they should ensure clear referral pathways into crisis and community services, provide staff training in safe de-escalation and compassionate crisis management, and work with system partners on joint case management of high-intensity users, helping to reduce unnecessary conveyance to EDs and prevent crisis escalation

In addition to the above, the provider will meet statutory obligations under the Mental Health Act 1983 and respond in line with locally agreed protocols, including:

- transport to hospital following assessment and/or detention in the community under the Mental Health Act
- conveyance to a place of safety for individuals detained under Section 136, including provision of an urgent response for transfers between places of safety
- transport of patients on community treatment orders (CTOs) who are being recalled to hospital

6.3.7 Palliative care and end of life care patients

All NHS ambulance service clinicians should have appropriate knowledge, skills and confidence to care effectively for patients with palliative care and end of life care needs, with access to specialist palliative care advice whenever needed.

All NHS ambulance service clinicians should have ready access to advanced emergency treatment / care plans (for example, ReSPECT) for people in end-of-life care, so they can

comply with the patient's wishes with regard to their preferred place of care (which may be at home) in the event of an emergency or at the end of their life.

Subject to local clinical determination, ambulance services should undertake same day transfer of all end of life care patients (expected to live no longer than 48 hours) within the service's geographical area to their preferred place of care.

6.4 Emergency Preparedness, Resilience, and Response (EPRR)

As both a 'Category 1' responder under the Civil Contingencies Act 2004 and as a provider of NHS funded services with a NHS Standard Contract, the provider must be able to plan for and respond to a wide range of incidents and emergencies which could affect the health of the population or the delivery of patient care. The NHS England EPRR Framework (2022) defines these incidents and emergencies as major incidents, critical incidents, and business continuity incidents. Providers are required to maintain arrangements to respond to these incidents while maintaining routine patient services.

The NHS core standards for EPRR are the minimum requirements the provider must meet, and across the ten core domains and one ambulance specific domain, they contain the NHS legal duties within the Civil Contingencies Act, NHS Act (2006) and other associated legislation. For NHS emergency ambulance services there is an additional specific domain including interoperable capabilities which covers HART, SORT, mass casualty vehicles, command & control and JESIP (interoperability standards in the UK).

The provider is required to annually undertake a self-assessment against the NHS core standards for EPRR, the result of which is agreed at a Public Board meeting, stated publicly in the annual report, and shared with commissioners as part of the NHS annual EPRR assurance process.

The eleven domains of the NHS Core Standards for EPRR, including the ambulance service specific domain, are:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control

5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Hazardous material (HAZMAT) and chemical biological radiological nuclear (CBRN)
11. Ambulance interoperability capabilities

The NHS England EPRR Framework (2022) also outlines additional specific roles for NHS ambulance services, these are:

Ambulance tactical adviser – the NHS emergency ambulance service will ensure the provision of on-call ambulance tactical advisers who are subject matter experts. They will be appropriately equipped and competent to give appropriate advice to the ambulance tactical commander and, if necessary, the ambulance strategic commander. Tactical advisers can also be called on to give advice to ambulance staff and managers in support of risk assessing and responding to unusual incidents. The ambulance tactical adviser may be required to attend the scene of the incident or emergency, a tactical coordinating group (TCG) and/or a strategic coordinating group (SCG).

Medical support – the NHS ambulance service must have in place arrangements for the provision of medical support in the event of a mass casualty incident.

7. Operational delivery

7.1 Optimised delivery model

More can be done to achieve an optimised delivery model in NHS ambulance services and maximise opportunities for productivity gains. An optimised delivery model reflects a shift from a traditional pick-up-and-convey-model to a proactive, integrated, and flexible clinician led emergency and urgent care model that supports right care, right time, right place, and improves efficiency, patient outcomes and patient experience.

The provider will:

- ensure EOC call handling capacity meets demand, with the ability to flex capacity to meet known surges in demand
- use approved transport options, where it is safe and appropriate to do so
    - this could include collaboration with locally commissioned taxis, PTS or volunteer transport to use availability for lower acuity patients and to protect emergency ambulance resource for the sickest patients
    - these services must be risk assessed and staff have the appropriate DBS checks, as well as having reporting mechanisms available
- use the NHS England national demand and forecasting planning tool to ensure a consistent planning approach is applied across the country to reduce variation
    - this advanced bespoke modelling tool has been developed to predict workforce, ambulance, and productivity needs, and will consider the impact of hospital handover delays and demand assumptions
    - the planning tool should also be used to determine capacity to meet demand, including periods of surge, aligned to local forecasting tools
- ensure rotas are matched with patient demand 24/7 to deliver performance in line with operational plans
    - this includes ensuring fleet availability, keeping unavailable time to a minimum.
- optimise fleet mix and ensure sufficient conveying resource to meet demand.

7.2 Demand management and escalation

Ambulance services use the national Resource Escalation Action Plan (REAP) to manage periods of sustained high demand or operational pressure. The four REAP levels correspond to Operational Pressures Escalation Levels (OPEL) which is used by other NHS organisations. Level 1 is the normal operational state rising to level 4 which indicates extreme pressure. REAP levels are a key part of the service's overall EPRR arrangements. They provide a framework to maintain an effective and safe operational and clinical response for patients.

In addition, the provider will have a demand management / clinical safety plan which is a dynamic tool to ensure a consistent approach during periods of excessive inbound call volume / event generation and/ or reduction in planned resource levels. The provider will ensure the demand management / clinical safety plan:

- is designed to ensure safety for the sickest patients

- has appropriate governance to support approval of the demand management / clinical safety plan
- is regularly reviewed and updated based on learning
- has systems and processes in place to monitor the effectiveness

To support system working the provider should ensure that they understand the wider health system OPEL levels and the contribution they make in reducing system pressure.

7.3 Vehicles and equipment

All new vehicles, particularly double-crewed ambulances (DCAs), must be procured in line with national requirements. The provider will:

- implement the national standard specification for new DCA fleet across England including a standard load list of equipment, consumables and medicines
- request a derogation from NHS England for any deviations from the national specification; deviations from the national specification must only be implemented if a derogation is received
- ensure timely submission of vehicle orders through the procurement process to ensure delivery is in line with capital allocations
- achieve the correct balance of fleet procurement, balancing replacement of older vehicles with the introduction of additional ones where required
- implement a phased approach to transition to electric vehicles, in line with the NHS net zero travel and transport strategy
- ensure fleet availability is maximised through proactive planning of servicing and replacement programmes
- prepare vehicles in advance of clinical staff coming on shift by adopting a ‘Make Ready’ type approach wherever possible
- reduce vehicle downtime and optimise fleet composition to ensure sufficient conveying resources to meet demand
- consider setting Vehicle off Road (VOR) and other fleet key performance indicators to support fleet productivity

7.4 Reducing unwarranted variation

The provider will, with support from ICBs and NHS England, reduce unwarranted variation in service delivery and clinical care, across the ambulance sector including work to reduce health inequalities. This will include:

- increasing opportunities for implementing the Category 2 streaming principles in full
- reducing variation in 'Hear and Treat' (currently 8.5% to 21.7%)[1] and 'See and Treat' (currently 26.2% to 35.2%),[3] rates between NHS ambulance services
    - this will be achieved through consistent monitoring, reporting and alignment of operational process
    - data should be disaggregated by age, sex, deprivation and ethnicity to ensure against widening health inequalities
    - progress will be reviewed monthly and research undertaken to understand what types of community capacity are most effective in preventing an avoidable conveyance

7.5 Quality and safety

Ambulance services play a crucial role in patient safety and quality, focusing on timely and appropriate care.

The provider must adhere to the legislation and statutory guidance for statutory safeguarding programmes and commissioning assurance as laid out in Section 3 of the NHS Safeguarding Accountability and Assurance Framework 2024 and support all ambulance staff to achieve the intercollegiate documents on safeguarding competencies.

The provider will also:

- have a board level Quality Assurance Committee which has oversight of all aspects of quality and safety
- have clear lines of professional and clinical safety and quality responsibility and accountability
- demonstrate compliance with the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines with a clear process for reporting any deviation from national guidance

[3] Source - Ambulance Quality Indicators April 2025 to August 2025

- ensure alignment with the Care Quality Commission (CQC) and other quality bodies including processes for controlled drugs
- have effective systems and processes in place to identify, report and respond to patient safety incidents, including learning from them and preventing future occurrences
- align with the Patient Safety Incident Response Framework (PSIRF) set out by NHS England
- learning from deaths including having a policy which aligns to the national framework, undertake mortality reviews and report data to appropriate quality governance committees
- define how patient experience will be monitored and improved
- specify how patient feedback will be collected, analysed and used to improve services and how impact of changes to services will be monitored and reported
- comply with the most up to date versions of the 999-triage tool and that quality assurance / audit processes meet requirements
- ensure clinical supervision time is allocated and learning from recent incidents is regularly updated
- comply with specific requirements for equipment, including maintenance, cleaning and testing
- prioritise infection prevention and control measures to protect both patients and staff from healthcare-associated infections; this includes:
    - adhering to infection prevention and control guidance
    - maintaining robust safeguarding training
    - having policies and procedures to enable consistency in protecting vulnerable patients
    - ensuring staff are trained to identify and respond to situations where patients may be vulnerable or at risk of harm
- have clear processes in place for monitoring and tracking medicines including reporting of any missing drugs
- engage with the ambulance quality indicators and national audits

7.6 Workforce planning and delivery

The provider will ensure workforce planning and development is a priority. This includes:

- collaborative planning with all relevant ICBs to ensure workforce strategies align with system-wide goals and evolving patient needs
- continued implementation of the Ambulance Culture Review recommendations (also see section 7.7)
- Take positive steps to ensure inclusive recruitment practices, with proactive outreach to support employment opportunities within marginalised communities
- ensuring NHS ambulance services have sufficient call handling capacity to manage call demand while continuing to support programmes to improve national call handling interoperability and resilience
- ensuring that levels of planned EOC clinicians are sufficient to deliver the level of clinical assessment required to meet demand
- a focus on senior clinical decision-making and clinical triage early in the patient journey
- implementing processes to reduce staff sickness and attrition rates
- reducing time on scene to optimise patient outcomes

7.7 Improving culture

The provider will, with support from ICBs, deliver the recommendations of the Ambulance Culture Review of NHS ambulance services to support improved leadership, improved workforce wellbeing, reduce sickness, improve attrition and improve clinical safety and outcomes. This will include:

- providing development opportunities so staff can react effectively to the changing demand, while promoting portfolio working within the local system to help provide further staff opportunities
- all staff must have access to a line manager, with the ratio of staff to management creating enough time for one-to-one clinical supervision
    - it is acknowledged that each NHS ambulance service will have their own model, policies, and guidelines, for delivering clinical supervision
- the provider will have a chief paramedic on their executive board to support a chief medical officer who is accountable for clinical safety

- the provider must deliver against their bespoke equality, diversity and inclusion plans including sexual safety, bullying, discrimination and harassment
- the provider will ensure the effectiveness of Freedom to Speak Up functions allow staff to report discrimination and harassment without fear of reprisal and uphold all ambulance policies, taking appropriate action and ensuring that all ambulance staff act with integrity
- enable cultural change through greater collaboration and shared learning between ambulance and ICB teams
- quarterly updates on people, operational performance, incident reporting and learning from incidents to be discussed at ICB level