

Commissioning Framework: A Framework for the Commissioning of Ambulance Services

NHS England Publications Gateway Reference: 08040

Commissioning Framework

A Framework for the Commissioning of Ambulance Services

Version number: v0.7

First published: 27th September 2018

Updated: (only if this is applicable)

Prepared by: NHS England Central Ambulance Team

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact the NHS England Central Ambulance Team on england.ambulance@nhs.net

1 Contents

1	Executive summary	5
2	Purpose	6
3	Background	7
3.1	Current Commissioning Arrangements.....	7
3.2	Transformation of Ambulance Services.....	7
3.3	Benefits of the Commissioning Framework	9
4	Commissioning Framework	11
4.1	Commissioning Approaches.....	11
4.2	Roles, Responsibilities and Actions.....	11
4.3	National Urgent and Emergency Ambulance Services Specification.....	13
4.4	What do I need to do?	14
4.5	Emergency Preparedness, Resilience and Response (EPRR) / Mutual Aid	23
5	Future Developments	26
6	Appendix One – National Urgent and Emergency Ambulance Services Specification	27
7	Appendix Two - Commissioning Framework – Self-Assessment Template.....	41

1 Executive summary

The recent National Audit Office review of Ambulance Services highlighted the variation across ambulance service performance and efficiency and the way they are commissioned and delivered. A subsequent recommendation from the Public Accounts Committee (March 2017) specified the need to develop a more standardised approach to the operational delivery and commissioning of ambulance services.

There have also been a number of national policy developments; specifically the Next Steps on the NHS Five Year Forward View, Urgent and Emergency Care Delivery Plan, Integrated Urgent Care Specification, emerging commissioning landscapes for health and social care services, the implementation of the Ambulance Response Programme across England and the Operational Productivity and Performance in English NHS Ambulance Trusts: Unwarranted Variations review. All of these will result in significant changes in the delivery and commissioning of urgent and emergency care services.

Within the context of the above, the National Ambulance Improvement Programme (AIP) asked the National Ambulance Commissioners Network (NACN), a member of the NHS Clinical Commissioners, to develop a Commissioning Framework and a National Urgent and Emergency Ambulance Services specification to support system leaders to reduce unwarranted variation in the commissioning and delivery of ambulance services.

This Commissioning Framework has been designed for use by any Commissioner, Sustainability and Transformation Partnership (STP), Integrated Care System (ICS) or equivalent individual or team when commissioning the regional ambulance service. To ensure the Framework is fit for purpose for a range of commissioning models and approaches, the term system or system leader is used when referring to any of the above, and their role as a commissioner of ambulance services.

Utilisation of this Commissioning Framework, the National Urgent and Emergency Ambulance Service Specification and implementation of the recommendations from the Operational Productivity and Performance in English NHS Ambulance Trusts: Unwarranted Variations Review will support a reduction in unwarranted variation in the commissioning and delivery of ambulance services.

2 Purpose

This Commissioning Framework has been developed as a simple, easy to use document to support system leaders in reducing unwarranted variation in the way ambulance services are provided and commissioned.

The Framework is designed to support system leaders to work in a collaborative way, encouraging open and transparent discussions with providers and other partners in the wider urgent and emergency care system to achieve the best outcomes for patients.

It is strongly recommended that system leaders use this Framework when commissioning the regional ambulance service in accordance with the NHS Standard Contract and the National Urgent and Emergency Ambulance Services Specification (Appendix One).

3 Background

3.1 Current Commissioning Arrangements

The current commissioning of ambulance services in England was developed following the introduction of the Health and Social Care Act 2012. Clinical Commissioning Groups (CCGs) are responsible for commissioning ambulance services, on a regional footprint.

CCGs often work collaboratively to commission ambulance services, with one CCG in the region taking the role of Co-ordinating Commissioner for the purposes of the NHS Standard Contract. More information on collaborative commissioning is available in the NHS Standard Contract Technical Guidance, and model Collaborative Commissioning Agreements are published on the [NHS Standard Contract web page](#).

As STPs and ICSs develop and provide new commissioning landscapes for health and social care services, current commissioning models for ambulance services will need to be reviewed.

3.2 Transformation of Ambulance Services

In recent years a number of reviews and programmes have been undertaken that have focused on transforming the delivery of ambulance services with the aim of specifically improving outcomes for patients.

3.2.1 Next Steps on the NHS Five Year Forward View (5YFV)

The Next Steps on the NHS Five Year Forward View encompasses national service improvement priorities for the NHS. A key priority within this strategy is the transformation of Urgent and Emergency Care (UEC). As such the UEC Delivery Plan was developed and issued to both NHS England regional leads and STPs in April 2017.

The ambulance work stream within the forward view and UEC delivery plan aims to improve the clinical outcomes and operational performance of the ambulance service and to provide a more equitable and clinically focussed response that meets patient needs in an appropriate time frame.

3.2.2 Ambulance Response Programme

In 2015, NHS England commissioned the Ambulance Response Programme (ARP), an independently evaluated trial to test new ways of working for the ambulance service. The aims of the ARP were to:

- Prioritise the sickest patients, to ensure they receive the fastest response;
- Drive clinically and operationally efficient behaviours, so that patients get the response they need first time and in a clinically appropriate timeframe; and

- Put an end to unacceptably long waits by ensuring that resources are distributed more equitably amongst all patients contacting the ambulance service.

The ARP incorporated changes to both clinical and operational standards and was approved for national adoption in July 2017. National implementation was phased with all mainland ambulance services live by the end of November 2017. The revised Ambulance Quality Standards are available on the NHS England website: www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators

3.2.3 National Audit Office Review of Ambulance Services

The National Audit Office (NAO) published a review of Ambulance Services in January 2017; this review was an update of the 2011 *‘Transforming NHS Ambulance Services’* report. The report identified a number of key findings including increasing demand, challenges in relation to resources, increasing system pressures, the use of different operating frameworks, inconsistent commissioning arrangements and difficulties implementing new models of care.

The 2017 NAO report highlighted a number of elements that result in variation in the way ambulance services are commissioned and delivered. These include:

- The level of demand the service is commissioned to meet, including call handling
- Resourcing – staffing, skill mix
- Funding – local prices, sustainability of services
- Fleet mix – ratio of ambulances and rapid response vehicles (RRVs)
- Estates – configuration of estates
- System – hospital handover, service reconfigurations, availability of alternative pathways

Following the NAO report, Lord Carter launched the Operational Productivity and Performance in English NHS Ambulance Trusts: Unwarranted Variations Review in June 2017. The review is due to be published in Autumn 2018. It will make a series of recommendations to improve productivity, efficiency and national critical infrastructure resilience and interoperability across ambulance services. This includes the design and production of a benchmarking tool for trusts: The Model Ambulance Service portal. System Leaders are required to work with the ambulance service, NHS Improvement, NHS England and other national bodies to ensure that action is taken to implement these recommendations, as part of an agreed plan.

3.2.4 Public Accounts Committee March 2017

The key findings and recommendations of the NAO report were discussed further at a Public Accounts Committee (PAC) held in March 2017. The PAC made a number of recommendations, one of which stated:

“NHS Improvement should determine the underlying causes of variations in performance, identify an optimal operating framework for ambulance services and work with NHS England to incorporate this framework into commissioning arrangements for 2018-19. The new framework and commissioning arrangements should establish commonality, but allow flexibility where appropriate”.

3.2.5 Emerging Commissioning Landscape for Urgent and Emergency Care

Following publication of the Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 the NHS and local councils have come together in 44 areas across England to develop proposals to improve health and care outcomes of the local population. As such a number of urgent care systems are beginning to come together to develop integrated models of care that support the delivery of care closer to home.

It is widely recognised that these emerging commissioning landscapes require continued integration and collaboration and that ambulance services and commissioners are integral to this system-wide approach.

3.2.6 Integrated Urgent Care Specification

The Integrated Urgent Care Specification sets out the vision for an Integrated Urgent Care Clinical Advisory Service (CAS). It is NHS England’s expectation that the CAS will become the key coordinating function for urgent care needs. In order to achieve this, providers and commissioners of urgent care services will be required to collaborate and engage with providers and commissioners of ambulance services to ensure more consistent access for patients with urgent care needs.

The CAS can provide clinical support / intervention to reduce the burden on 999 services, ensuring only those patients who really need an ambulance are sent one. The relationship between the CAS provider and the ambulance service is integral to this.

The IUC specification offers a unique opportunity to align both the commissioning and provision of ambulance services within urgent care systems.

3.3 Benefits of the Commissioning Framework

There are a number of benefits to utilising this Commissioning Framework as part of the commissioning process:

- Improved patient outcomes with patients directed to the right service, first time.
- Reduction of unwarranted variation in ambulance service operational delivery and national critical infrastructure resilience and interoperability.
- Facilitation of collaborative and integrated commissioning including a shared vision and strategy for urgent and emergency care services.

OFFICIAL

- Reduction in unwarranted variation in ambulance service delivery and commissioning arrangements.
- Consistent commissioning processes and approaches and improved sharing of best practice. This will support sustainable service delivery and commissioning going forward.
- Reduced duplication and fragmentation of commissioned services through collaborative agreements and joined up commissioning intentions and arrangements.
- Formalised and improved system integration with alignment through contractual obligations.

4 Commissioning Framework

4.1 Commissioning Approaches

There are a range of commissioning models and approaches that can be adopted as part of the commissioning of ambulance services:

- Lead Commissioner.
- Integration of urgent and emergency care.
- STPs and ICSs.

As these are still emerging and encompass large scale change, system leaders may need to consider the adoption of features from a number of different approaches on the journey to fully integrated commissioning arrangements.

4.2 Roles, Responsibilities and Actions

4.2.1 Roles and Responsibilities

Effective relationships and collaboration are fundamental to the successful commissioning and delivery of the ambulance service, regardless of the commissioning approach that is taken.

4.2.2 System Leader Responsibilities

The System Leader with responsibility to lead on ambulance service commissioning should:

- (i) Commission ambulance services as an integral part of the urgent and emergency care system according to national requirements and standards.
- (ii) Ensure patient outcomes are at the heart of everything they do.
- (iii) Provide system leadership and ensure the ambulance service is an integral part of system planning and collaboration.
- (iv) Work with colleagues to agree the role and function of the system leader and the wider system partners during the contracting period.
- (v) Ensure governance arrangements, roles and responsibilities are clearly defined within an appropriate agreement or contract.
- (vi) Collaborate with colleagues within the Urgent and Emergency Care system to develop and agree a shared vision and understanding that supports alignment and integration of services. Ensure the ambulance service is recognised in the context of wider provision.

- (vii) Negotiate and agree a contract that delivers national performance, clinical and quality standards, incorporating any known challenges and improvement plans into the contract. Where appropriate, recommendations from the Operational Productivity and Performance in English NHS Ambulance Trusts: Unwarranted Variations Review and the subsequent plan should be incorporated within contract arrangements.
- (viii) Performance manage the contract against the Operational Standards and National Quality Standards set out in the NHS Standard Contract (<https://www.england.nhs.uk/nhs-standard-contract/>).
- (ix) Be accountable for the delivery of national performance clinical and quality standards, working collaboratively with providers should performance improvement plans be required.
- (x) Ensure the ambulance service is clear on, and has plans to meet, their contractual, performance, quality, transformational and financial objectives, and critical infrastructure resilience and interoperability.
- (xi) Provide support and challenge to the ambulance service; holding the ambulance service to account for planning guidance deliverables.
- (xii) Be assured of the ambulance services level of emergency preparedness.
- (xiii) Show regard to the legislative duties in respect of equality and health inequalities. Guidance to support Clinical Commissioning Groups (CCGs) in meeting these legal can be found at <https://www.england.nhs.uk/about/equality/equality-hub/legal-duties/>.
- (xiv) Ensure alternative health services are in place and responsive to patient need. System leaders will be required to achieve greater alignment with the commissioning of urgent health and social care services in the community.

4.2.3 What Should System Leaders expect from providers?

System leaders should expect the following from providers:

- (i) Deliver core 999 requirements as detailed within the National Urgent and Emergency Ambulance Services Specification.
- (ii) Deliver the service in line with national requirements and standards including performance, clinical and quality standards.
- (iii) Deliver critical infrastructure resilience and interoperability requirements, working collaboratively with NHS oversight bodies as required.
- (iv) Maintain a focus on patient outcomes.

- (v) Deliver the National minimum EPRR standards as detailed in the NHS England EPRR Framework. Be able to state the level of emergency preparedness of the service if and when required.
- (vi) Commitment to implement and deliver an effective and efficient operating model in line with patient demand, the recommendations of the Operational Productivity and Performance in English NHS Ambulance Trusts: Unwarranted Variations Review and the associated plans for implementation.
- (vii) Collaborate, integrate and engage with system and key partners. The system and key partners will be defined when determining the commissioning approach.
- (viii) Participate in open and transparent dialogue in respect of service delivery and performance against national standards and requirements.
- (ix) Implement key clinical quality care pathways as set out nationally (e.g. for patients who have fallen).
- (x) Collaborate with other ambulances services across England and NHS oversight bodies to identify, codify and share evidence of based best practice including the delivery of a common operating model for ambulance services across England.

4.3 National Urgent and Emergency Ambulance Services Specification

The National Urgent and Emergency Ambulance Services Specification (Appendix One) incorporates the core elements for delivery of urgent and emergency ambulance services, and must be used when commissioning emergency ambulance services.

The service specification details a five stage framework, providing a structure through which ambulance services and commissioners can work together to deliver the principles of the Five Year Forward View and Urgent and Emergency Care Delivery Plan. The five stages are:



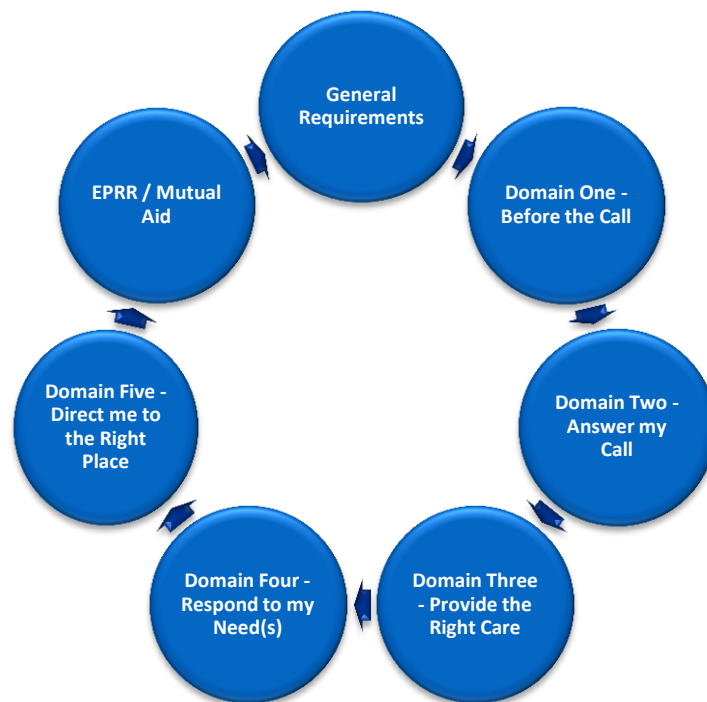
This model of delivery places emphasis on early clinical decision making. Within each of the five elements, ambulance services will need to deliver against national performance, clinical and quality standards and locally agreed indicators, whilst maintaining local autonomy that reflects the diverse patient and geographical demographics across England.

System Leaders must commission the ambulance service based on the national performance standards that prioritises 999 calls into Categories 1 – 4 and hear and treat, including delivery of the associated national performance, clinical and quality standards.

4.4 What do I need to do?

A number of key activities are required to facilitate the effective commissioning of ambulance services, reduce unwarranted variation in the commissioning process and operational delivery and demonstrate value for money. These are required irrespective of the commissioning approach that is implemented.

These activities have been broken down into general requirements incorporating actions to be undertaken, commissioning domains that follow the five stage framework described above and included within the National Urgent and Emergency Care Service Specification and EPRR/ mutual aid.



Implementation of the general requirements and commissioning domains, along with delivery of a common operating model for ambulance services across England, will support the reduction in unwarranted variation of service delivery. It will also ensure the patient knows what to expect from the ambulance service and receives the right service, at the right time, and in the right place.

A self-assessment has been developed (Appendix Two) to allow System Leaders to assess the current position against these domains. This will support effective commissioning of ambulance services and will address the PAC recommendation of reducing unwarranted variation.

4.4.1 General Requirements

1. Commissioning Approach

Working collaboratively across urgent and emergency care services including the production of a shared vision and strategy across urgent and emergency care services is integral to achieving the best outcome for patients and also the sustainability of services.

The 2015 Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 set out the direction of travel for more integrated and collaborative commissioning. It also recognised the need for an engaging and iterative process to achieve integration.

In determining the commissioning approach to be used system leaders will be required to:

- Collaboratively agree the commissioning approach to be undertaken. This may be a phased approach from one form to a more integrated and collaborative approach over an agreed timeframe.
- Design and implement a lean and effective governance structure and agree terms of reference for all meetings within it.
- Clarify and agree roles and expectations of all key stakeholders within the system. The system may include commissioning, STP and ICS representatives, the ambulance service, NHS111 and IUC CAS, other urgent and emergency health and social care services and blue light partners.
- Cultivate open and transparent relationships:
 - Facilitate an effective relationship between system leaders, the ambulance service and system partners that cultivates open and transparent dialogue.
 - Provide both support and challenge to the ambulance service where required.
- Ensure the ambulance service is a key stakeholder within the wider healthcare system including STPs/ ICSs, A&E Delivery Boards and other local groups;
 - As a regional provider, the ambulance service may face a number of challenges such as a requirement to engage with an increased number of systems. System Leaders and providers and may also need to feed in to a number of plans. System Leaders should provide support to the ambulance service to address any challenges that arise.
- Agree communication channels at the outset, in line with the agreed governance structure.

- Agree a process for Contract Management as set out in the NHS Standard Contract:
 - Provide support and challenge to the ambulance service on all elements of the contract.
 - Where performance or quality standards are not achieved, undertake a detailed analysis, in collaboration with the ambulance service, to understand why and agree improvement plans in accordance with the NHS Standard Contract. Be mindful that actions within the improvement plan may be the responsibility of wider system partners.

2. Shared Vision, Strategy and Plans

A shared vision and strategy will set out how stakeholders within the urgent and emergency care system will collaborate to achieve improved integration, reduce unwarranted variation and duplication and work together to improve patient outcomes.

The shared vision, strategy and delivery plans should clearly articulate the interfaces between both the ambulance service and the wider urgent and emergency care commissioning, if this is not integrated.

System leaders should:

- Develop and agree a shared vision for urgent and emergency care.
- Ensure the ambulance service is integral to the development of the strategy.
- Work towards removing duplication across the urgent and emergency care system.

The ambulance service and system leaders must collaborate to co-design the system and develop effective pathways for urgent and emergency care including integrated 999 and NHS 111 call handling and triage. A collaborative approach will support ambulance services to share and manage demand more appropriately and reduce conveyance to ED.

3. Commissioning Intentions

Commissioning intentions provide a basis for constructive engagement between the System Leader and the ambulance service and inform contracts. They are intended to drive improved outcomes for patients and should capture both the core and transformational activities required to do this.

System Leaders should:

- Develop and agree commissioning intentions that support the needs of the patient population commensurate with the agreed commissioning approach.

- Develop commissioning intentions collaboratively with key stakeholders. Key stakeholders will be defined when agreeing the commissioning approach.
- Develop commissioning intentions in a reasonable timeframe to inform contract negotiations and contract development.
- Ensure the commissioning intentions include known transformational activities that will be required during the contract period.

4. Contract Agreement

The NHS Standard Contract is the mandated form of contract for the commissioning of the ambulance service and is available on the NHS Standard Contract web page at <https://www.england.nhs.uk/nhs-standard-contract/>.

Information on using the NHS Standard Contract is available in the Contract Technical Guidance (available via the Contract web page) and queries on using the Contract may be sent to the NHS Standard Contract team at nhscontractshelp@nhs.net.

The NHS Standard Contract supports collaborative commissioning and different models of commissioning, such as a lead provider model and alliance contracting (please refer to the Contract Technical Guidance for more information).

System Leaders should:

- Agree the form of the commissioning approach.
- Following negotiation agree a financial settlement that supports delivery of an effective and efficient ambulance service. This should include:
 - Development of a payment system that incentivises safe non-conveyance through hear and treat and see and treat responses.
 - Ensure the payment system supports the outcomes of the Five Year Forward View. Any financial disincentive to increase opportunities for hear and treat and see and treat, where it is clinically safe and appropriate to do so, may result in the ambulance service continuing to transport patients to a Type 1 or Type 2 ED.
- Commission the ambulance service to deliver:
 - Core 999 services including delivery of the national performance, clinical and operational standards.
 - A resilient and nationally interoperable service, working collaboratively with NHS oversight bodies as required.

- Emergency Operations Centres with Clinical Hub/ Coordination Centre provision.
- EPRR minimum requirements as detailed in the NHS EPRR Framework. This will include the development of disaster recovery standards working collaboratively with NHS oversight bodies as required.
- HART and other services to support EPRR as detailed in the NARU HART service specification (<https://naru.org.uk/naru-publishes-hart-service-specification-2016-17/>).

4.4.2 Domain One – Before the Call (Health Prevention and Promotion)

Domain One encompasses the development of strategies and plans to better manage demand before the call.

1. Public Education and Guidance

System Leaders will need to:

- Ensure the ambulance service has strategies and plans in place to undertake public education and guidance regarding the appropriate use of the ambulance service.
- Ensure the ambulance service has plans and processes in place to manage high intensity users such as frequent callers and care establishments.
- Ensure the ambulance service is commissioned and is resourced to engage in activities to assist in partnership initiatives that lead to better education and health management of the population and patients.
- Work with the ambulance service to implement initiatives that focus on demand management.

4.4.3 Domain Two - Answer my Call (Improved Clinical Support at Contact Centres)

Domain Two encompasses the activity of answering 999 calls and is focused on improved prioritisation of 999 demand.

1. Prioritisation of 999 emergency ambulance demand

Systems Leaders will need to:

- Ensure the ambulance service answers all 999 calls, including calls from healthcare professionals and calls transferred from NHS 111, promptly.
- Ensure the ambulance service is able to assess and triage calls via an accredited triage tool. Consideration should be given to moving towards a

standardised triage tool across all ambulance services in England to enable efficiencies and ensure patients receive an appropriate level of care.

- Ensure the ambulance service is able to provide clinical advice as soon as possible in the call process (either by a clinician or a clinical based system applied by a non-clinician). This also means working collaboratively with the Integrated Urgent Care CAS to ensure the patient is assessed and treated by the most appropriate service in line with clinical need. Wherever possible, a best practice operating model and associated protocols for clinical assessment should be implemented in all ambulance control centres throughout England.
- Provision of clinical support hub functions in Emergency Operation Centres and/or Clinical Coordination Centres. In an integrated and collaborative model this will incorporate links to Integrated Urgent Care CAS.
- Ensure ambulance services have Demand Management Plans and REAP processes in place that can be implemented at times of increased pressure (see domain four for more information).

4.4.4 Domain Three – Provide the Right Care (Patients Receive an Appropriate Response)

Domain three encompasses the ability of the ambulance service to provide the right care, in the right place at the right time.

1. Provide the Right Care, in the Right Place, at the Right Time

The ambulance service must be able to appropriately assess the needs of patients and provide the most appropriate response in a timely way, which may not be an emergency ambulance.

Systems Leaders will need to:

- Ensure the ambulance service is able to provide a range of interventions appropriate to clinical need including:
 - Hear and Treat.
 - See and Treat.
 - See, Treat and Convey – includes conveyance to services other than Type 1 and Type 2 EDs.

A full definition of each of these is available within the Ambulance Quality Indicators (www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators).

System Leaders and the ambulance service are required to safely reduce conveyance, where this is clinically appropriate, by increasing opportunities for

“hear and treat” and “see and treat” and through the introduction of alternative pathways of care.

- Ensure the ambulance service has the tools and systems to accurately assess and appropriately respond to patients referred by healthcare professionals as part of wider system management.

4.4.5 Domain Four – Respond to my Need(s) – Use Resources Effectively and Responsibly

Domain four encompasses responding to patient need whilst ensuring that resources are used effectively and responsibly.

In order to achieve this, systems leaders will need to ensure that the ambulance service has the most effective operating model.

The operational model should be discussed and agreed during contract negotiations and form part of ongoing contract management and monitoring.

1. Operational Model

1.1 Demand

- System Leaders and the ambulance service should agree an indicative level of demand during the contract term:
 - Have a clear and agreed understanding of the level of anticipated demand, taking into consideration expected surge periods.
 - Where demand is expected to exceed capacity, work collaboratively with the provider to agree how to manage this in accordance with the NHS Standard Contract. This could include implementation and development of demand management schemes and a channel shift to “hear and treat” and “see and treat” where appropriate.
 - Work with system partners to understand any initiatives that may impact on demand such as service reconfigurations or wider urgent and emergency care commissioning decisions. Ensure the ambulance service is engaged early in the process and any impact on the ambulance service is jointly agreed. Where required, develop a plan for inclusion within the demand plans/contract.
 - Have an understanding of the impact of increasing “hear and treat” and “see and treat” volumes on the job cycle time, specifically on scene, and ensure that this is included in service planning. This should be viewed in line with the wider benefits of reducing avoidable conveyance for patients, the ambulance service and the wider health system.

1.2 Capacity

- Be assured that the provider has the staffing levels and appropriate skill mix to meet the agreed level of demand. This should include a process for gaining further assurance during surge periods.
- Support the transition to the new band 6 paramedic job description, ensuring that paramedics have the training, support and commissioned service alternatives to safely avoid hospital conveyance when clinically appropriate. Consider the further professional development of ambulance clinicians (e.g. paramedic practitioners) to improve the clinical service provided to patients whilst ensuring alignment with the system workforce plan, where this is available.
- Ensure the ambulance service has a common clinical supervision model, in line with national requirements.
- Support the ambulance service to have timely access to a range of health care professionals such as mental health nurses, pharmacists, GPs and community service specialists such as physiotherapists and occupational therapists. This could be via collaboration and engagement with the Integrated Urgent Care CAS.
- Ensure processes are in place to quickly and effectively address system pressures which impact on service delivery such as hospital handover delays and hospital diverts when these arise. Work with A&E Delivery Boards and other stakeholders to ensure the delivery of agreed plans for minimising handover delays in line with national guidance.

1.3 Operational Delivery

- Be assured that the ambulance service has an effective and efficient operating model that meets the agreed demand profile and achieves national performance, clinical and quality standards and critical infrastructure resilience, working collaboratively with NHS oversight bodies as required. This includes:
 - A rota pattern that meets demand, including implementation of a rota and demand management approach.
 - Efficient and resilient control centre, call taking and dispatch infrastructure and processes, in line with national interoperability and critical infrastructure requirements with appropriate telephony and CAD to CAD linkages.
 - The right vehicle and staff skill mix to meet demand, in line with the requirement for all ambulance services to move towards a common specification for vehicles and load lists.
 - A suitable estate configuration.

- Effective support and “make ready” systems.
- A system of support and governance for clinicians. System Leaders should provide strong clinical leadership and a balanced approach to ensure this is maintained and continuously improved.

1.4 Demand Management

- Ensure the ambulance service has robust demand management plans and processes in place.
- Ensure the ambulance service has agreed REAP escalation and implementation processes in place.

4.4.6 Domain Five – Direct me to the Right Place (Make sure the Right Outcome is Achieved)

Domain Five encompasses ensuring the right outcome for the patient’s clinical need is achieved.

System Leaders will need to:

1. Ensure the patient receives the right outcome for their clinical need

- Only convey patients to an ED when it is clinically appropriate to do so.
- Ensure the ambulance service has access to a range of alternative health care providers including access to general practice and community services. To reduce avoidable conveyance, ambulance staff will need to be aware of and be able to easily access and refer to a range of alternative health care services in the community. Every effort should be made to access existing channels such as the *5 initiative and wider expertise available in the Integrated Urgent Care CAS.
- Work with STPs and the ambulance service to regularly review the effectiveness of change in the configuration and accessibility of health services in the community and any impact on conveyance.
- Ensure the ambulance service works with system leaders to assist with the development and access of the multi-disciplinary CAS function, to ensure this service is available to ambulance service clinicians and enables the direct referral of patients from EOC clinicians and dispatchers to a wide range of community based services.
- Ensure the ambulance service works with local partners, commissioners and systems to identify gaps in alternative provision.

2. Ensure access and usage of a range of digital enablers to support clinical decision making

In order to effectively direct the patient to the right place, the ambulance service is required to have a range of digital enablers in place to support clinical decision making and patient care. System Leaders are required to:

- Ensure the ambulance service collects the NHS number of all patients contacting the service (via the Patient Demographic Service (PDS)), where this is possible. For Category One calls, the ambulance service may want to collect this once the call has concluded.
- Ensure that all clinicians within the ambulance service have immediate access to, and are accessing, patient records. The System Leader should work with the provider to agree a plan to improve the number of views and should provide additional support to the ambulance service where access to patient information is limited.
- Ensure the ambulance service has immediate access to, and is utilising, an easily navigable electronic directory of services that provides access to service information. System leaders should encourage and support the ambulance service to increase the effective utilisation of these services, in addition to providing support where referrals have been unsuccessful. System Leaders and the ambulance service must work together to ensure that the directory of services is up to date and easily accessible to frontline ambulance staff at scene at all times.

4.5 Emergency Preparedness, Resilience and Response (EPRR) / Mutual Aid

System Leaders and ambulance services hold a number of responsibilities in respect of EPRR:

1. The requirements for ambulance services are also listed within the NHS England EPRR Framework (<https://www.england.nhs.uk/ourwork/epr/gf/>)
2. The ambulance service will provide services, planning and service capability to deliver its obligations as a Category 1 Responder as laid down in the Civil Contingencies Act 2004 and in line with the requirements of the Department of Health's Emergency Planning Guidance (2005).
3. The System Leader and the ambulance service will work cooperatively with the other emergency services and other Category 1 and 2 responders, including but not limited to participating in the planning and exercise testing processes.
4. The System Leader will commission EPRR requirements as laid down in the NHS England EPRR Framework.
5. The Ambulance Service and System Leader will work cooperatively with the Home Office National Interoperability programme.

The full statutory responsibilities for ambulance services are detailed within the Civil Contingencies Act (2004) and are available via the following links:

<https://www.gov.uk/government/publications/emergency-preparedness> 1.29 - 1.31 in Chapter 1
<https://www.gov.uk/government/publications/emergency-response-and-recovery> sections 3.2.12 - 3.2.16.

Within this Act ambulances services are designated Category 1 Responders. Category 1 Responders are organisations at the core of the response to most emergencies and as such are subject to civil requirement duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Put in place business continuity management arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance coordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.

The minimum EPRR standards, which all NHS organisations and providers must meet, are set out in the NHS England Core Standards for EPRR. There is a core standards matrix available on the NHS England webpage that provides a consistent cohesive framework for both self-assessment and assurance processes (<https://www.england.nhs.uk/publication/core-standards-for-emergency-preparedness-resilience-and-response-epr/>).

Since 2012 responsibility for delivery of emergency preparedness policy in ambulance services in England has been delegated to the NARU. NARU is funded directly by the Department of Health and Social Care and collaboratively coordinates implementation of government policy, producing service specifications, standard operating procedures, training programmes, and other guidance to provide consistency in local delivery and a national capability where necessary.

The use of the NHS England Core Standards for EPRR will facilitate robust commissioning of EPRR requirements and ensure standardised systems and processes are in place to enable ambulance services to fulfil statutory requirements.

Contractual obligations in relation to EPRR are detailed in Service Condition 30 within the National Standard Contract.

The contract with the ambulance service should clearly set out the EPRR requirements. It should include:

OFFICIAL

1. Hazardous Area Response Team (HART) capacity and capability in line with the HART specification published on the National Ambulance Resilience Unit (NARU) website.
2. Capacity and capability for Marauding Terrorist Fire Arms Attack (MTFA) uplift staff and their availability 24/7.
3. Requirement to attend statutory multi-agency planning including Safety Advisory Groups (SAGs) on behalf of the local health economy including associated planning processes.
4. Specific response requirement and capacity required to attend both Strategic Command Groups (SCGs) and Tactical Command Groups (TCGs) within each Local Resilience Forum area which they cover.
5. The requirement to comply with the current published NHS England EPRR Framework and associated guidance.
6. Mass Casualty response capability in line with the NHS England Concept of Operations for managing mass casualties and agreed pre dispersal model across the health economy.
7. Trained, competent and compliant cadre of Commanders available to support the management of an incident or incidents 24 hours a day 365 days a year in line with national requirements including but not limited to National Incident Liaison Officers (NILO) trained staff.
8. The development and adoption of disaster recovery standards for control centres and organisational critical infrastructure, working collaboratively with NHS oversight bodies as required.

System Leaders are also required to ensure that providers of NHS Emergency Ambulance Services are compliant with the Marauding Terrorist Firearms Attack (MTFA) standard as described in the NHS England Core Standards for EPRR. The core standards include the requirement 'Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).

Systems Leaders should use the following supporting documentation:

[Ambulance Service. Guidance for Preparing an Emergency Plan
Emergency preparedness, resilience and response. A guide for ambulance
commissioners
https://www.england.nhs.uk/wp-content/uploads/2015/11/epr-framework.pdf](https://www.england.nhs.uk/wp-content/uploads/2015/11/epr-framework.pdf)

5 Future Developments

There are a number of ongoing programmes that will support and impact upon the commissioning and delivery of the ambulance service. System Leaders will need to be cognisant of these and ensure they are included within commissioning and contracting arrangements.

These include:

- Implementation of the forthcoming recommendations from the Operational Productivity and Performance in English NHS Ambulance Trusts: Unwarranted Variations Review, including commitment to deliver a common operating framework for ambulance services across England.
- The development of a 'Model Ambulance Service' portal for ambulance services by NHS Improvement.
- The ongoing work of the Ambulance Improvement Programme.
- A long-term plan to safely reduce ambulance conveyance to type 1&2 EDs by 2023 by providing effective clinical support and community-based alternatives to conveyance.
- The future commissioning and system landscape including STPs and ICSSs.
- Integration of health and social care and alignment with other services.
- Introduction of a national ambulance dataset (ADS). System Leaders and ambulance services will be required to comply with the requirements of a single national data set as necessary

6 Appendix One – National Urgent and Emergency Ambulance Services Specification

Service Specification

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement

Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Urgent and Emergency Ambulance Services
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs
<p>1.1 <u>National/local context and evidence base</u></p> <p>Ten Ambulance Service Trusts provide emergency and urgent care services for 54 million people in England. In addition the Welsh Ambulance Service, Scottish Ambulance Service, and Northern Ireland Ambulance Service provide care for Wales, Scotland, and Northern Ireland respectively. The Isle of Wight is managed under a separate arrangement.</p> <p>Demand for these services has grown consistently over the past 15 years and continues to do so. Trusts are also seeing a rise in the clinical acuity of patients presenting via 999.</p> <p>The combination of the 999 and calls from NHS 111 Services means that UK Ambulance Service Trusts are now the providers of 11 million episodes of care each year. The need to provide enhanced triage and clinical decision making in Ambulance Contact Centres is crucial in the context of the national policy drivers set out in the NHS Five Year Forward View (5YFV).</p> <p>Contraction in available funding to support growth and the delivery of cost improvement programmes is driving a more radical approach to service delivery change, requiring Ambulance Services to reconsider their service delivery models in order to both meet the current financial and demand pressures and to position themselves in a strategically strong position in order to be responsive to changes</p>

occurring across the region.

The Urgent and Emergency Care Review published in 2013 and updated in 2015 set two primary objectives:

- For those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services 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.
- For those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities, in order to maximise their chances of survival and a good recovery.

It is important to recognise that the 999 service is part of the wider NHS system providing integrated patient care, and should be commissioned as such.

Provision of 999 services is aligned closely with national and regional initiatives driven by:

- Sustainability and Transformation Partnerships.
- Integrated Care System.
- Integrated Urgent Care systems (i.e. NHS 111, Clinical Assessment Services, Urgent Treatment Centres, GP Out of Hours Services, etc).

Additionally, regional Ambulance Trusts may collaborate closely with other ambulance services, the wider emergency services or wider system providers to deliver appropriate patient care.

To support the service transformation agenda, the key requirements are:

- To deliver the core response and clinical outcome standards as defined by the Ambulance Response Programme.
- To fulfil statutory duties relating to emergency preparedness, resilience and response (EPRR).
- Optimisation of call handling and appropriate responses through virtual alignment of NHS 111/999 and call/ CAD transfer between ambulance services.
- Increase the percentage of lower acuity calls managed through "hear and treat" and "see and treat" options.
- Utilise a virtual delivery model to support wider workforce integration for paramedics, call handlers and specialist staff with local urgent care delivery models.

- Facilitate cross boundary working and the flexible use of ambulance service resources to support the development of regional Sustainability and Transformational Plans and Integrated Care Systems.

This new Service Specification has been developed collectively with commissioners and providers of Paramedic Emergency Services. NHS England will continue to work with commissioners during the implementation and delivery of the Specification.

The 999 service is free for the public to call and is available 24 hours a day, 7 days a week, to respond to the population of England with a personalised contact service when patients:

- Require rapid transportation with life threatening illness/injury or emergencies (category 1 & 2).
- Present with lower acuity urgent and less urgent conditions (category 3 & 4) requiring clinical interventions.
- Patients may be passed to 999 via other NHS health care systems, including NHS 111.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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 environment and protecting them from avoidable harm	

The provision of a high-performing, safe and effective 999 service can be mapped to the domains within the NHS Outcomes Framework.

CCGs are required to commission a service based on the Ambulance Response Programme model that prioritises 999 calls into four new categories:

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

As the Integrated Urgent Care Service model becomes embedded this will support ambulance services to further develop “hear and treat” and “see and treat” models.

2.2 Local 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 need.

3. **Scope**

To meet the combined challenges of the safe management of high acuity patients, who make up a minority of activity, whilst also addressing the needs of the larger volume of mid and low acuity patients, against the backdrop of a finite funding position, Ambulance Services and Commissioners understand and recognise the need to work differently.

This will require a coordinated programme of service transformation, working to a common framework that delivers all key principles of patient care.



This five stage framework will provide a structure through which ambulance services and commissioners can work together to deliver the principles of the 5YFV and Urgent and Emergency Care Delivery Plan. It places an emphasis on early clinical decision making that will ensure the delivery of care is commensurate with the clinical needs of our patients. Within each of the five elements, Trusts will need to deliver against mandatory expectations, whilst maintaining local autonomy that reflects the different patient and geographical demographics across the UK.

3.1 Before the call



The aims and objectives of the service before the call include any strategies to better manage potential patient demand by:

- Follow the principles of the NHS Constitution and engage with Public Health England to provide public education and guidance regarding the appropriate use of 999 ambulance services.
- Activity management through education and management of known high intensity users, both individual patients and care establishments such as nursing homes and hospitals.

- Use of tools and systems to accurately assess response against the clinical needs of patients referred by Healthcare Professionals.

The provider must be resourced and supported to engage in activities to assist in partnership initiatives that lead to better education and health management of the population and patients and ensure the best use of the services. Such initiatives may be the subject of local initiatives or be commissioned directly according to local requirements.

3.2 Answer my call



Answering the call involves better prioritisation and management of 999 demand and those NHS 111 calls that are passed to the ambulance service for a response through:

- Provision of clinical advice as soon as possible in the 999 call process (either by a clinician or a clinical based system applied by a non-clinician).
- Provision of clinical support hub functions in Emergency Operations Centres / Clinical Co-ordination Centres.
- Apply best practice in line with national guidance to provide clinical intervention and validation of patients accessing 999 care via NHS 111.

The Provider will deliver the following response services every day of the year on a 24 hour basis for the following response services:

- 999 response (including Healthcare Professional Activity).
- Emergency Operations Centres / Clinical Co-ordination Centres.
- HART and similar services to support EPRR (Such services are detailed separately in accordance with the current published National Specification).

The service is provided for people with life threatening emergencies and urgent health care needs. It is accessed through the following routes:

- Direct access via a 999 call for ambulance service assistance by a person who is in the geographical area of the NHS Ambulance Trust.
- A request from a Healthcare Professional for the urgent transfer of a patient to a healthcare setting on the grounds of an urgent clinical need, such as medically expected patients who have been assessed by the HCP and

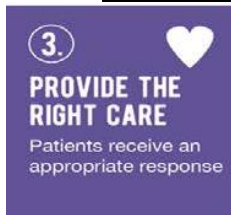
require transportation to an acute facility within specified timescales.

- Police and / or Fire Service Computer Aided Dispatch (CAD) Link or direct line.
- NHS 111 calls passed to the 999 Ambulance Service.

During periods of increased service pressures, the Provider will operate in accordance with locally agreed REAP escalation levels. Where appropriate, this will include clinical or operational support facilitated by the local Commissioner from other Health economy providers.

The Provider is to assess and triage all calls, using an accredited triage tool to assess the required response, as received from the public via the 999 telephone system and calls received from Healthcare Professionals and other emergency services, utilising an approved IT system in accordance with guidance published from time to time by NHS England. The provider will ensure that telephony systems are fully compliant with Ambulance Service Trusts position as a CAT1 responder under the Civil Contingencies Act.

3.3 Provide the right care



Providing the right care, in the right place, and at the right time ensures that Ambulance Trusts appropriately assess patient needs and provide the most appropriate response in a timely way. This response may not be an emergency ambulance and could include:

- Embedding the Ambulance Response Programme principles into the EOC / CCC call management service.
- Utilising Pre-Determined Attendance (PDA) recommendations against the existing operational response model.
- Streaming appropriate patients and clinical advice calls to the wider healthcare system, using properly integrated technical systems.

A patient triage, either by telephone or face to face, will be undertaken by an appropriately qualified person. The triage event will be documented on an Electronic Patient Report (EPR) record or a paper record if EPR is not available. Where an EPR is not available plans must be in place to implement an EPR. Following an appropriate assessment, immediate and necessary interventions will be undertaken to preserve life where possible, and support a person's clinical condition.

The Provider will ensure patients receive appropriate interventions as follows:

- **Hear and Treat / Refer:** Incidents with no face to face response. Calls will be managed via the Clinical Support Desk resulting in no resource (vehicle) arriving at the scene. Hear and Treat / Refer service is to be available and staffed with appropriately qualified staff 24 hours per day. A successfully completed call is one where advice has been given with any appropriate action being agreed with the patient and where no further response is required from the ambulance service. Appropriate action may include telephone advice and 'signposting' or referral to any appropriate service such as GP, Out of Hours Service, Urgent Treatment Centre (UTC), Pharmacy, NHS 111, CTA etc.
- **See and Treat:** Calls which resulted in an emergency response arriving at the scene and where following assessment and / or treatment no onward conveyance was required (but with advice and appropriate 'signposting' or referral to alternative services).
- **See and Convey:** Calls which result in an emergency response arriving at the scene, followed by ambulance conveyance to a healthcare facility. If there have been multiple calls to a single incident then only 1 (one) incident should be recorded. Through the Ambulance Quality Indicators ambulance services are required to distinguish between conveyance to a type 1 or 2 ED and conveyance to an alternative service.

Local Commissioners, working with the ambulance service, will determine targets for "Hear & Treat", "See & Treat", and "See & Convey" subject to guidance issued by NHS England.

The provider is required to implement key clinical quality care pathways, e.g. those relating to falls, sepsis, mental health and others as they become available and are set out nationally.

3.4 Respond to my need(s)



Responding to my need(s) includes:

- Using an NHS Accredited triage system to undertake call prioritisation linked to Pre-Determined Attendance methodology to establish the right response for every patient, first time, in order to reduce 'over responding' and improve utilisation.
- Subject to local determination, providing remote advice for responding staff to enable patients to be managed safely either in, or close to their home environment, wherever possible.
- The Provider will have appropriate mechanisms in place to access electronic

plans of care and these will be routinely shared with clinicians operating in the Provider's Services. The Commissioner working with clinical leads is responsible for making care plans available and for ensuring these are relevant and up to date.

- Using lower acuity accredited transport options, where it is safe and appropriate to do so.

The Ambulance Response Programme places an emphasis on making sure the most appropriate clinical response is provided for each patient first time and every time.

Ambulance services are measured on the time it takes from receiving a 999 call to a vehicle arriving at the patient's location. Under the new national performance standards there are four categories of call which acknowledge that many patients do not require an immediate response. However those that do will be prioritised in a way that increases the chance of survival and a good outcome.

The categories, which set out mandatory response times across all levels of acuity are reproduced below. Delivery standards are in accordance with the NHS Ambulance Quality and Clinical Indicators, which may be updated from time to time.

Categories	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	7 minutes mean response time	The earliest of: •The problem is identified •An ambulance response is dispatched	The first ambulance service-dispatched emergency responder arrives at the scene of the incident
	15 minutes 90 th centile response time	•30 seconds from the call being connected	(There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	18 minutes mean response time	The earliest of: •The problem is identified •An ambulance response is dispatched	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
	40 minutes 90 th centile response time	•240 seconds from the call being connected	

Category 3	120 minutes 90 th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 4	180 minutes 90 th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

3.5 Direct me to the right place



Directing me to the right place means that the Provider will:

- Work with local Commissioners to assist with the development of the Multi-disciplinary Clinical Assessment Service (CAS) function, to enable direct referral of patients from EOC clinicians and dispatchers to a wide range of community based services.
- Work with local partners and Commissioners to identify areas where there is a need to develop referral pathways for patients who have called 999. These may utilise or build upon existing arrangements in NHS 111. The Provider can expect a local Commissioning response that enables pathways of care that maximise the Provider's ability to manage patients in the community and ensures that unnecessary transport to hospital is minimized.
- Provide immediate access to, and utilisation of, an easily navigable electronic directory of services, shared patient records and remote decision support in a mobile format to enable referral to services following telephone and face to face assessment. It should be noted that sufficient and robust DoS maintenance procedures must be assured at local level.

3.6 Any acceptance and exclusion criteria and thresholds

The Provider will provide Urgent and Emergency ambulance services to all potential patients resident in or travelling through the area of responsibility of the ambulance

Provider.

In addition the following services will be provided:

3.6.1 National Framework for Inter-Facility Transfers

Emergency (high priority) hospital admissions should be managed in accordance with national guidance disseminated through the National Framework for Inter-Facility Transfers as follows.

This framework is intended for patients who require transfer by ambulance between facilities due to an increase in either their medical or nursing care need. The definition of a facility which this framework applies to are healthcare facilities that provide inpatient services. In some locally determined situations an additional “facility” will be defined by the ambulance service as suitable to use the IFT process i.e. urgent care centres with direct admitting rights to inpatient services.

Patients who have immediate life-threatening injuries or illnesses should be transferred, where necessary with an appropriate hospital escort, and within a set timeframe mapped to national performance categories defined below. Similarly, patients with serious or urgent healthcare needs should be transferred in an appropriately commissioned timeframe. Local systems should have commissioned arrangements in place for the return of personnel and equipment to facilities.

The following framework should be used so that individual systems can develop standard operating procedures and decision algorithms.

A set of inter-facility transfers levels will be described with a clear definition of the patient groups that would be allocated to each level. Those levels will be mapped to the current ARP categories and Ambulance Trusts would be expected to respond to these requests under the same response levels as other 999 calls.

There will be 4 levels of inter-facility response:

IFT Level 1 (IFT1) Category 1

This level of response should be reserved for those exceptional circumstance when a facility is unable to provide immediate life-saving clinical intervention such as resuscitation and requires the clinical assistance of the ambulance service in addition to a transporting resource. These requests should be processed through the Trusts 999 Triage tool and only those that are deemed category 1 under that assessment should receive a category 1 response. Examples would include Cardiac arrest, anaphylaxis, birth units requiring immediate assistance, or acute severe life-threatening asthma in an urgent care facility.

IFT Level 2 (IFT2) Category 2

This level of response is based on the need for further intervention and management rather than the patient’s diagnosis. Immediately Life, Limb or Sight (Globe trauma) Threatening (ILT) situations which require immediate management in another facility should receive this level of response.

For instance, patient going directly to theatre for immediate neurosurgery, immediate Primary Percutaneous Coronary Intervention, Stroke Thrombolysis, immediate limb or sight saving surgery or mental health patient being actively restrained.

These IFT level 2 patients would be mapped to category 2 response under ARP. A specific set of interventions as detailed above should be strictly adhered to.

IFT Level 1 and Level 2 incidents are confirmed emergencies which require life-saving intervention and should be responded to as time critical emergencies and immediately allocated the nearest emergency ambulance.

There should be little or no variation in the proportions of the above categories across England.

IFT Level 3 (IFT3) optional to be Locally commissioned response

This level may be commissioned for patients who are not undergoing immediate life or limb saving interventions but require an increase in their level of clinical care as an emergency. Where this is commissioned a set timeframe for the level of response should be specified between 30 minutes and 2 hours.

This level of response may include mental health crisis transfers or those solely for the purpose of creating a critical care bed

IFT Level 4 (IFT4) Locally determined response

This is for all other patients who do not fit the above definitions and require urgent transport for ongoing care but do not need to be managed as an emergency transfer. Patients being transferred to inpatient wards for ongoing management or for elective and semi elective procedures or investigations. This category of patient will have a timeframe outside of the ARP standards and will be determined through their normal commissioning arrangements.

Patients who do not fit the definitions above are not appropriate for a Category 1, 2 or 3 response from the ambulance service. In some cases patients with immediately life or limb threatening conditions may not be ready for transfer within the Category 1 or 2 timeframe and require further management before being clinically suitable for transfer. In those cases a lower category will be allocated to reflect the time delay until the patient is ready for transfer.

Repatriations or step down transfers/discharges to non hospital facilities are not intended to be included in the IFT framework.

3.6.2 End of Life Care patients

Subject to local clinical determination, same day transfer of all End of Life Care Patients (expected to live no longer than 48 hours) within the Provider's geographical area to their preferred place of care.

3.6.3 Mental Health patients

Subject to local clinical determination, transport for patients with a mental disorder (as defined in the Mental Health Act 1983 (MHA); This includes formal patients (i.e., those detained under the MHA) and informal patients (i.e. those not detained under the MHA) who require:

- Transport to hospital following assessment and / or detention in the community. Response to this type of incident will be in accordance with locally agreed procedures.
- Transport to a designated place of safety for those who have been detained under Section 136 of the MHA.
- The initial response to a Section 136 request will require that a clinician, suitably qualified to complete an initial screening ensures that the patient has no underlying medical condition affecting their mental state at the time. Subsequent transfer (if required) from initial designated place of safety to alternative designated place of safety should be an urgent response (in accordance with locally agreed procedures).
- Requests to upgrade an urgent response to an emergency response may be made in certain circumstances where clinically indicated (i.e. where the patient's condition requires a quicker response for example when the patient is extremely agitated / anxious but compliant) or where the environmental situation is compromised to the detriment of the patient, to be undertaken in accordance with locally agreed procedures.
- Transport of patients on a Community Treatment Order being recalled to hospital.
- Patients who have been sedated before being conveyed should always be accompanied by a healthcare professional that is knowledgeable in care of such patients, is able to identify and respond to any physical distress or complications which may occur and has access to the necessary emergency equipment to do so.
- Agreements will be in place with police and mental health providers based on these parameters, those outlined in the Mental Health Act Code of Practice 2008 and the Mental Health Crisis Care Concordat.

3.7 Exclusions to the Service include:

Unless stipulated within this 999 specification, all other journey types will be excluded and subject to local determination.

3.8 Clinical Quality Indicators:

Ambulance Services should report, and seek to continuously improve, clinical quality indicators as specified by NHS England. This includes performance

standards such as those relating to stroke and heart attack patients. For example, see:

<https://www.england.nhs.uk/wp-content/uploads/2017/07/ambulance-response-programme-letter.pdf>

3.9 Interdependence with other services / providers

The Provider must be fully consulted on, and will then work with local Commissioners / CCGs to respond to and support, any local reconfiguration of services.

Local Commissioners will work proactively with the Provider and other relevant stakeholders to eliminate delays in patient handover at ED, and in accordance with standards set and monitored by NHS Improvement. The Provider will expect the impact on ambulance services to be modelled should handover times exceed the specified standards.

Reference: <https://www.england.nhs.uk/wp-content/uploads/2017/11/ambulance-handover-letter.pdf>

3.10 Vehicles and Equipment

All new fleet vehicles, particularly double-crewed ambulances (DCAs), should be procured in line with national requirements. The provider is required to implement the standard specification for new DCA fleet across England including a standard load list of equipment, consumables and medicines, and the inclusion of CCTV and “black box” technology.

3.11 Ambulance Service Transformation

The provider is required to engage with the national transformation agenda and is committed to implementation of the recommendations of the Operational Productivity and Performance in English NHS Ambulance Trusts: Unwarranted Variations Review which requires a commitment to the delivery of a common operating model for ambulance services across England including:

- Standardised call triaging systems, process and rules.
- A best practice operating model and protocols for clinical assessment in the control centre.
- Common protocols and models of support for paramedics on scene to safely reduce avoidable conveyance .
- Convergence in the technical infrastructure and common standards with shared call handling capacity and CAD interoperability across the system in the longer term.
- Development and implementation of nationally agreed disaster recovery standards for service delivery and critical infrastructure, working collaboratively with NHS oversight bodies as required.
- Ensuring the rapid testing and deployment of innovation, including the enablement of new technology.

- Implement make ready systems, where appropriate, across the country.

4. Applicable Service Standards

- 4.1 Applicable national standards (eg NICE).**
- 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. the medical Royal Colleges)**
- 4.3 Applicable local standards**

5. Applicable quality requirements and CQUIN goals

- 5.1 Applicable quality requirements (See Schedule 4 Parts A-D)**
- 5.2 Applicable CQUIN goals (See Schedule 4 Part E)**

7 Appendix Two - Commissioning Framework – Self-Assessment Template

The self-assessment template has been designed to support System Leaders to assess the current position against the requirements detailed within the Commissioning Framework. The template provides considerations to support System Leaders in their commissioning of ambulance services. The template acts as a gap analysis to support System Leaders on the journey towards integrated commissioning of urgent and emergency care.

Guidance for Completion:

The template provides the opportunity for Systems Leaders to assess the current position and identify any actions required. Completion of the self-assessment template should be undertaken by System Leaders in collaboration with the ambulance service.

Level Key

Level 1 not in place/ not effective	Level 2 In place / limited effectiveness	Level 3 In place/ reasonably effective	Level 4- In place / fully effective.
---	--	--	--

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
General Requirements				
Commissioning Model and Approach				
A commissioning approach has been agreed.	<ul style="list-style-type: none"> The current commissioning approach is defined and agreed with key stakeholders. Consider the current model and approach 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	and any changes that might occur during the contract term.			
	<ul style="list-style-type: none"> Consideration has been given to a range of different models and approaches including lead commissioner model, integration of urgent and emergency care, STPs and ICSs. Consider whether a phased approach from one approach to another is deliverable within the contract term and actions required to implement this. 			
	<ul style="list-style-type: none"> Consider the collaboration required between System Leaders responsible for the commissioning of ambulance services, integrated urgent care and the wider urgent and emergency care system. System Leaders will need to consider how to best collaborate now and in the future. 			
	<ul style="list-style-type: none"> Consider the role of current commissioning functions within and across the urgent 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	and emergency care system to support delivery of integrated urgent care.			
A collaborative governance structure is in place to support the commissioning model, approach and contract delivery.	<ul style="list-style-type: none"> The governance structure has been reviewed and reflects the requirements of the contract for ambulance services and the integration of urgent care. Ensure the governance arrangements are clear about decision making processes including decisions relating to finance, activity and other contract arrangements. The governance arrangements should be robust, clear, agreed by all parties including the responsibilities and remit of meetings within the governance structure. 			
	<ul style="list-style-type: none"> The governance structure incorporates clinical governance arrangements. Consider any collaboration between the ambulance service and integrated urgent care, where appropriate. Consider clinical leadership 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	requirements.			
	<ul style="list-style-type: none"> Terms of reference have been agreed and are fit for purpose. 			
	<ul style="list-style-type: none"> All key stakeholders are represented at relevant forums. Where gaps arise this is escalated accordingly. 			
	<ul style="list-style-type: none"> Communication channels are defined and agreed. 			
	<ul style="list-style-type: none"> The governance structure facilitates learning and sharing of best practice to improve patient outcomes. 			
Roles, requirements and expectations of all key stakeholders have been clarified.	<ul style="list-style-type: none"> Roles and expectations of all stakeholders have been outlined and agreed to ensure roles and responsibilities are clear. Consider collaborative working between the ambulance services and other providers of urgent and emergency care including Integrated Urgent Care. 			
	<ul style="list-style-type: none"> A plan is in place to engage with any stakeholders who are not adequately represented. 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	<ul style="list-style-type: none"> Communication channels are defined and agreed. 			
Relationships are effective to support the commissioning and delivery of ambulance services.	<ul style="list-style-type: none"> Effective working relationships and collaboration facilitate open and transparent dialogue about all elements of delivery. Consider current relationships and any actions required to improve collaboration, support and challenge. 			
	<ul style="list-style-type: none"> Collaboration and engagement exists across all appropriate health care systems and services and with other blue light services. 			
	<ul style="list-style-type: none"> The ambulance service is a key stakeholder within the wider healthcare system. Any challenges are identified and support provided as required. 			
The contract management process is agreed.	<ul style="list-style-type: none"> The contract management process is agreed, as set out in the NHS Standard Contract In line with governance 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	structures the process for contract management is agreed. Consider arrangements to monitor finance, demand, national performance, clinical and operational standards, system pressures and transformation initiatives.			
Shared Vision, Strategy and Plans				
There is an agreed shared vision and strategy for urgent and emergency care.	<ul style="list-style-type: none"> The shared vision and strategy incorporates both the current commissioning approach and the desired future approach. Consider a phased approach and the steps required to move to the future model. 			
	<ul style="list-style-type: none"> The ambulance service and System Leaders have collaborated to co-design the system and develop effective pathways for urgent and emergency care including integrated 999 and NHS 111 call handling and triage. 			
	<ul style="list-style-type: none"> The shared vision and strategy clearly sets out the roles and requirements of all 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	services including the ambulance service.			
	<ul style="list-style-type: none"> Mechanisms are in place that allow System Leaders, providers and the public to collaboratively come together to design services. 			
	<ul style="list-style-type: none"> The shared vision, strategy and plans clearly articulate the interface between both the ambulance service and wider urgent and emergency care commissioning, where this is not integrated. 			
A plan has been developed that details actions required to improve collaborative working and remove duplication across the urgent and emergency care system.	<ul style="list-style-type: none"> Do the plans include integration or alignment between the ambulance service and wider urgent and emergency care services 			
Commissioning Intentions				
Commissioning Intentions have been developed, shared with system stakeholders and agreed.	<ul style="list-style-type: none"> Commissioning Intentions have been developed and are reflective of the requirements to achieve national performance, clinical and quality standards and deliver a sustainable resilient ambulance service. If 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	national performance, clinical and quality standards have not been achieved in the previous contract term, consider how this can be addressed. Consider anticipated demand, based on modelled evidence.			
	<ul style="list-style-type: none"> The commissioning intentions include core delivery including EPRR requirements and the requirement to develop disaster recovery standards, working collaboratively with NHS oversight bodies as required. Consider training needs and requirements to enable the ambulance service to achieve minimum standards within the NHS England EPRR framework. 			
	<ul style="list-style-type: none"> The commissioning intentions are reflective of any transformational activities that will be required. This could include integrated urgent care and wider system integration and 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	collaboration. Consider what can reasonably be achieved within the contract term.			
	<ul style="list-style-type: none"> Consider which stakeholders are required to support the development of the commissioning intentions. 			
	<ul style="list-style-type: none"> Legal and system considerations and impacts have been taken in to account for any procurement or disinvestment decisions. 			
Contract Agreement				
A contract form has been agreed.	<ul style="list-style-type: none"> The NHS Standard Contract is the mandated form of contract for commissioning ambulance services and is available on the NHS Standard Contract web page at https://www.england.nhs.uk/nhs-standard-contract/. Consider approaches such as alliance arrangements, collaborative commissioning agreements, outcome based contracts, and data sharing agreements. Refer to the Contract Technical Guidance 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	for more information.			
	<ul style="list-style-type: none"> The contract is fit for purpose and takes account of current and future state. Any proposed changes / steps to improve integration are captured. 			
	<ul style="list-style-type: none"> If required, advice in using the NHS Standard Contract has been sought from the NHS England National Contract Team at nhscontractshelp@nhs.uk 			
Contract negotiation has been undertaken and an appropriate financial settlement has been agreed.	<ul style="list-style-type: none"> A financial settlement has been agreed that delivers the strategy and achieves national performance, clinical and operational standards. The financial settlement is commensurate with indicative demand levels. 			
	<ul style="list-style-type: none"> The financial settlement for the wider urgent and emergency care system has been considered including opportunities for channel shift and joint working to 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	remove duplication.			
	<ul style="list-style-type: none"> Consideration has been given to any changes that might impact on the financial settlement during the contract term. 			
The contract agreement incorporates delivery of core 999 services, Emergency Operations Centres with Clinical Hub/ Coordination Centre provision and HART and other services to support EPRR as details in the NARU HART Service Specification.	<ul style="list-style-type: none"> Commission the ambulance service to deliver national performance, clinical and operational standards. 			
	<ul style="list-style-type: none"> Consider the relationships and links to the Integrated Urgent Care CAS and how low acuity calls could be managed. 			
Domain One – Before the Call (Health Prevention and Promotion)				
Public Education and Guidance				
The ambulance service participates in public engagement to ensure appropriate use of 999 services.	<ul style="list-style-type: none"> Commission the ambulance service to undertake public engagement to ensure appropriate use of 999 services. Consider public health messaging and format. 			
	<ul style="list-style-type: none"> Ensure the ambulance service participates in key public health initiatives as appropriate. 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	<ul style="list-style-type: none"> The ambulance service utilise forms of social media to share messages about appropriate use of 999. 			
The ambulance service has processes in place to manage high intensity users.	<ul style="list-style-type: none"> Ensure the ambulance service has processes in place to manage high intensity users. Consider frequent caller initiatives, education and partnership working with care and nursing homes, other health care providers such as NHS 111 and Primary Care and joint working with other blue light partners. 			
The ambulance service is commissioned and resourced to engage in activities to assist in partnership initiatives to promote better education and health management of the population.	<ul style="list-style-type: none"> Support ambulance services, as part of the wider system, to consider partnership initiatives to promote better education and health management. Consider education initiatives within the community, nursing and care homes local schools. 			
System Leaders work with the ambulance service to implement initiatives that focus on demand	<ul style="list-style-type: none"> Work with ambulance services to explore potential demand management initiatives and the impact 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
management.	these may have.			
Doman Two – Answer my Call (Prioritisation of 999 emergency ambulance demand)				
The 999 service answers all 999 calls promptly	<ul style="list-style-type: none"> The ambulance service is commissioned and resourced to effectively meet the anticipated call volume. 			
	<ul style="list-style-type: none"> The resource capacity plans are in line with anticipated demand plans and where possible consider and incorporate spikes in demand and seasonal surges. 			
The ambulance service is equipped with an accredited triage tool that enables them to assess and triage calls.	<ul style="list-style-type: none"> An accredited triage tool is embedded for both calls and clinical triage where these are different. 			
	<ul style="list-style-type: none"> Resilience plans are developed and embedded in the event that the triage tool is unavailable due to technical failure. 			
	<ul style="list-style-type: none"> Consideration is being given to the opportunity to move towards a standardised triage tool across all ambulance services across England. 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
The ambulance service has embedded clinical advice capabilities.	<ul style="list-style-type: none"> Clinical advice capabilities are embedded and appropriate to meet the anticipated demand 			
	<ul style="list-style-type: none"> Ensure the ambulance service has access to and is utilising digital enablers to support call takers and clinicians in their decision making (see Domain Five) 			
	<ul style="list-style-type: none"> Consideration has been given to how the ambulance service will link with the integrated urgent care CAS and where required this is reflected in the contract. 			
Domain Three – Provide the Right Care (Patients Receive an Appropriate Response)				
The ambulance service is able to provide a range of interventions appropriate to clinical need.	<ul style="list-style-type: none"> Ensure compliance with the national Ambulance Quality Indicators (AQIs). 			
	<ul style="list-style-type: none"> Indicative baselines for “Hear and Treat”, “See and Treat” and “See, Treat and Convey” are jointly agreed and reflected in the contract agreement. 			
	<ul style="list-style-type: none"> For “Hear and Treat” clinical advice capabilities are embedded as detailed in 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	Domain Five - digital enablers.			
	<ul style="list-style-type: none"> For “See and Treat” the ambulance service employs a clinical skill mix range to treat patients closer to home and. 			
	<ul style="list-style-type: none"> For “See, Treat and Convey” the ambulance service only conveys to T1&T2 EDs when clinically appropriate. System Leaders should commission a range of services as an alternative to ED including direct admission to appropriate hospital wards/ unit. 			
	<ul style="list-style-type: none"> Triage tools and systems are in place and embedded to accurately assess the response against clinical need. Resilience processes are in place in the event of any technical failures. 			
Domain Four – Respond to my Need(s) – Use Resources Effectively and Responsibly				
Operational Model				
Demand - An indicative level of demand during the contract term has been agreed.	<ul style="list-style-type: none"> Agree an anticipated demand based on historic trends and incorporate any 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	growth or reduction in demand. Consider the support required within the System Leaders commissioning team to support this work.			
	<ul style="list-style-type: none"> Consider any known or expected impact of any service reconfigurations and wider urgent and emergency care commissioning decisions and ensure these are reflected in the contract. 			
	<ul style="list-style-type: none"> Ensure there is an agreed process for the management of service reconfigurations and that the ambulance service is engaged early in the process. 			
	<ul style="list-style-type: none"> Consider links and collaboration with other urgent and emergency care services to manage demand including the Integrated Urgent Care CAS. 			
	<ul style="list-style-type: none"> Consider development of demand management schemes, where appropriate. 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	<ul style="list-style-type: none"> Ensure engagement between the wider system (STPs/ ICSs) planning teams and ambulance commissioners to ensure channel shifts are captured in CCG, STP and ICS financial plans. 			
	<ul style="list-style-type: none"> Have an understanding of the impact of “hear and treat” and “see and treat” volumes on the job cycle time, specifically on scene, and ensure it is included in service planning. 			
Capacity – The ambulance service has, or is working to establish, sufficient workforce to meet current and future demand.	<ul style="list-style-type: none"> System Leaders should be assured that the ambulance service: <ul style="list-style-type: none"> Has a workforce plan focused on urgent care. Has a system of support and governance for clinicians. Has the staffing levels and appropriate skill mix to meet the agreed level of demand. System Leaders should ensure there is an agreed 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	<p>process for gaining further assurance during surge periods (consider utilisation of Schedule 6A Reporting requirements – National requirements Reported Locally – 11 Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2)</p> <ul style="list-style-type: none"> ○ Supports the transition to the new band 6 paramedic job description, ensuring paramedics have the training, support and commissioned alternatives to safely avoid hospital conveyance when clinically appropriate. Consider the further professional development of ambulance clinicians to improve the clinical service provided to patients. 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	<ul style="list-style-type: none"> ○ The workforce plan takes account of Health Education England plans. 			
	<ul style="list-style-type: none"> • System Leaders should support the ambulance service to timely access a range of health care professionals to improve the clinical service provided to patients. Consider the collaboration and engagement with the Integrated Urgent Care CAS. 			
	<ul style="list-style-type: none"> • Ensure processes are in place to quickly and effectively address system pressures such as hospital handover and hospital diverts. 			
	<ul style="list-style-type: none"> • As System Leaders support the ambulance service to address system pressures with the wider system. This could including working with A&E Delivery Boards and other stakeholders to ensure the delivery of agreed plans for minimising handover delays in line with national 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	guidance.			
	<ul style="list-style-type: none"> • Ensure the ambulance service has a common supervision model, in line with national requirements. 			
Operational Delivery – The ambulance service has an effective and efficient operating model.	<ul style="list-style-type: none"> • System leaders should be assured that the ambulance service has: <ul style="list-style-type: none"> ○ a rota pattern that sufficiently meets demand, including implementation of a rota and demand management approach. ○ the vehicle mix is correct and sufficient to meet demand It is in line with the requirement for all ambulance services to move towards a common specification for vehicles and load lists. ○ Efficient and resilient control centre, call taking and dispatch infrastructure and processes ○ a suitable estate configuration 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	<ul style="list-style-type: none"> ○ effective support and “make ready” systems ○ A system of support and governance for clinicians. System Leaders should provide strong clinical leadership and a balanced approach to ensure this is maintained and continuously improved. 			
Demand Management – The ambulance service has demand management and escalation processes in place.	<ul style="list-style-type: none"> • System Leaders should be assured that the ambulance service has: <ul style="list-style-type: none"> ○ Robust demand management plans in place ○ Embedded REAP escalation and implementation processes 			
Domain Five – Direct me to the Right Place (Make sure the Right Outcome is Achieved)				
The patient receives the right outcome for their clinical need	<ul style="list-style-type: none"> • Patients should only be conveyed to ED when it is clinically appropriate to do so. System leaders should therefore ensure: <ul style="list-style-type: none"> ○ The ambulance service 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	<p>has access to a range of alternative health care providers including access to general practice and community services.</p> <ul style="list-style-type: none"> ○ Support engagement between the ambulance service, local partners, commissioners and systems to identify gaps in alternative service provision. 			
The ambulance service has use of digital enablers to support clinical decision making and patient care.	<p>System Leaders should work with the ambulance service to ensure access and usage of key digital enablers to support decision making and patient care. System Leaders should ensure:</p> <ul style="list-style-type: none"> • Ensure the ambulance service collects the NHS number during the call cycle for all patients contacting the service, where this is possible. For Category One calls, ambulance services should consider retrieval of the NHS Number at the end 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	of the call cycle.			
	<ul style="list-style-type: none"> Ensure that all clinicians within the ambulance service have immediate access to, and are accessing, patient records to support decision making. Where usage appears to be low, plans should be put in place to increase the number of views of patient records including providing support to ambulance services where access to patient information is limited. 			
	<ul style="list-style-type: none"> Ensure the ambulance service has immediate access to, and is utilising, an easily navigable electronic directory of services that provides access to service information. Encourage and support ambulance services to increase usage. Support an effective mechanism to allow ambulance services to collect gaps in alternative 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	service provision. <ul style="list-style-type: none"> Provide support where referrals have been unsuccessful. 			
EPRR / Mutual Aid				
The ambulance service is commissioned to deliver EPRR requirements as laid down in the NHS England EPRR Framework and is able to fulfil the responsibilities within the Civil Contingencies Act 2004.	<ul style="list-style-type: none"> The ambulance service is able to meet the minimum standards as set out in the NHS England Core Standards for EPRR. Disaster recovery standards are developed and adopted for control centres and organisational critical infrastructure working collaboratively with NHS oversight bodies as required. 			
	<ul style="list-style-type: none"> The core standards matrix has been undertaken and shared with System Leaders as required. There is a plan in place to mitigate against any identified gaps. 			
	<ul style="list-style-type: none"> There is a training plan in place to meet EPRR requirements. 			
	<ul style="list-style-type: none"> System Leaders are assured of the ambulance services ability to meet the EPRR 			

OFFICIAL

Domain Requirement	Considerations	Current Level (1 – 4)	Current Assessment and Supplementary Information/ Evidence	Action Required
	minimum standards. There is a process in place to continuously monitor progress, delivery and assurance.			