**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

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

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| **1. Population Needs** |
| **1.1 National/local context and evidence base**  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.  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.  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).  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 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 Transformational 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** |
| * 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.   * 1. **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.  1. Before the Call - health prevention and promotion 2. Answer my Call - improved clinical support at contact centres 3. Provide the Right Care - patients receive an appropriate response 4. Respond to my Need(s) - use resources effectively and responsibly 5. Direct me to the Right Place - make sure the right outcome is achieved  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**  Before the Call - Health Prevention and Promotion  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**  Answer my call - Improved clinical support at contact centres  Answering the call involves better prioritisation and management of 999 demand and those NHS 111calls 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**  Provide the Right Care - Patients receive an appropriate response  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)**  Respond to my Need(s) - Use resources effectively and responsibly  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    15 minutes 90th centile response time | The earliest of:  •The problem is identified  •An ambulance response is dispatched  •30 seconds from the call being connected | The first ambulance service-dispatched emergency responder arrives at the scene of the incident    (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    40 minutes 90th 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 3** | 120 minutes 90th 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 90th 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**  Direct me to the Right Place - Make sure the right outcome is achieved  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 anappropriately commissioned timeframe. Local systems should have commissionedarrangements 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 Section136 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** |
| * 1. **Applicable quality requirements (See Schedule 4 Parts A-D)**   2. **Applicable CQUIN goals (See Schedule 4 Part E)** |