To: The Board

For meeting on: 24 November 2016

Agenda item: 17

Report by: Miles Scott, Improvement Director

Report on: Ambulance Trust Sustainability Review

Introduction

1. The Ambulance Trust Sustainability Review was initiated in June this year in partnership with the Association of Ambulance Chief Executives, (AACE), and the NHS England Urgent & Emergency Care Programme to examine the following questions:

    - What are the key challenges in securing sustainable service provision across Ambulance Trusts in relation to:
        - Demand, capacity & operational performance?
        - Quality & clinical practice?
        - Workforce & leadership?
        - Finances?
    - How far are these challenges addressed by current provider and commissioner plans?
    - What are the key questions for organisation development and configuration in addressing these challenges?

2. The review team brought together a range of available data in relation to these questions for consideration at a workshop involving representatives from NHS Improvement, NHS England, AACE, NHS Clinical Commissioners, Health Education England (HEE), National Audit Office and Department of Health (DH). The key findings from the workshop are detailed at Appendix A.

3. This paper provides an update to the Board on the progress of the review and on the action being taken to address its recommendations.

Progress of the review

4. There is a unanimous view among the key stakeholders participating in the review that the current model and configuration of ambulance services is not sustainable. In each of the areas examined, (demand & capacity, operational performance, quality & clinical practice, workforce & leadership, finances), ambulance trusts face major challenges which will not be resolved within existing plans.

5. That said, there is significant agreement about the changes that are required both within ambulance services and across the wider Urgent & Emergency Care system in order to secure sustainability for the future. The key components of these changes are:

    - Rolling out changes in practice arising from the Ambulance Response Programme, (ARP), including the safe expansion of See & Treat and Hear & Treat models of care.
    - Implementation of the wider Urgent & Emergency Care Programme; in particular 7 day primary care, integrated clinical hubs in the community and action to reduce hospital handover delays.
    - Improving the capability of ambulance services to deal with the rising demand from medical and elderly patients. This requires significant staff development and better use of technology.
    - Addressing widespread issues of staff engagement and leadership.
    - Reducing overhead costs and improving operational productivity.
    - Co-ordinated and consistent commissioning of ambulance services to a common specification that is binding on commissioners as well as providers.

6. In addressing operational performance and clinical practice there is considerable agreement across all stakeholders on the action that needs to be taken to deliver these changes. What is required now is an implementation programme to see these actions through. In other areas, (notably finance, workforce and leadership), further work is required to determine what action needs to be taken and then to take this forward in a joint implementation programme.

7. There is also general agreement that addressing these challenges will require significant organisational development across the ambulance service. The review team identified a range of options in outline at its workshop. More work is required to understand these options better and at this stage there is a range of views about which would best support ambulance services and their key stakeholders in addressing the challenges they face. Nonetheless, there is general agreement that:

    - ‘Do nothing’ and ‘do minimum’ options are very unlikely to meet the challenges to be addressed.
    - Collaborative models offer the potential for consolidation of effort without the distraction of major organisational change. To be successful there needs to be an ability to gain traction universally and not allow disengagement, opting out or settling on the lowest common denominator.

- Organisational consolidation has the potential to secure the changes required. However, the process of merger or assembling a chain would consume a great deal of time and effort that could be a distraction from pursuing the changes outlined in paragraph 5 above.
- Other forms of organisational change, including tri-service integration, have interesting features but do not offer a compelling response to the challenges identified in this review.

Next Steps

8. The recommendations of this review are being taken forward in partnership with key stakeholders through the national Ambulance Workstream Coordination Group chaired by Prof Jonathan Benger. This group includes representatives from NHS Improvement, NHS England, National Ambulance Commissioning Network, DH, HEE, Care Quality Commission (CQC) and the AACE.

9. National workstreams are being established to take forward the changes outlined at paragraph 5:

    a. ARP roll out – led by Prof Benger, NHS England
    b. Wider Urgent & Emergency Care Reform Programme – led by Pauline Philip and Prof Keith Willett, NHS England
    c. Dealing with changing casemix – new workstream building on work already undertaken by HEE
    d. Staff engagement & leadership – new workstream to include input from unions and CQC
    e. Reducing cost & improving operational productivity – new workstream within NHS Improvement Operational Productivity Directorate

10. The review team is meeting again in December to input to the establishment of each of these workstreams and also to take forward the option appraisal of different approaches to organisational development and/or integration.

11. The recommendation to improve coordination and consistency of commissioning has been raised with the National Ambulance Commissioning Network and NHS England. Proposals for taking this forward will be presented to the national coordination group chaired by Prof Benger.

NHSI AMBULANCE TRUST REVIEW – KEY FINDINGS

1. DEMAND, CAPACITY & OPERATIONAL PERFORMANCE

Ambulance services are not able to meet the demand, capacity and operational requirements placed upon them as things stand. Operational performance has declined as demand has risen (and continues to rise) year on year. This is exacerbated by lengthy turnaround times at many hospitals and other service changes.

There is broad consensus about the actions required to address these challenges on a sustainable basis. These require a combination of:

I. Implementing plans for wider reform of urgent and emergency care across the NHS. The sustainability of ambulance services will rely in particular upon the successful development of seven day primary care services, integrated clinical hubs in the community and actions to reduce hospital handover times. Ambulance capacity will not cope with future demand without these changes, however much improvement activity is undertaken within ambulance services themselves.

II. Implementation of the national Ambulance Response Programme should enable ambulance services to provide a wider range of appropriate responses that better reflect changing patient needs, in particular:

- Increased use of See & Treat and Hear & Treat models
- Eliminating non-productive activity introduced to 'stop the clock'
- Increasing the scope of paramedic practice, (in particular in relation to medical and elderly patients)
- Standardising operational practice
- Working with community clinical hubs

III. Consistent commissioning of ambulance services across England, supporting and resourcing the developing models of care that most appropriately respond to patient needs.

2. QUALITY AND CLINICAL PRACTICE

Changes in casemix mean that ambulance services need to be better able to manage medical and elderly patients than is typically the case at present, but without any loss of capability to respond to trauma. The pressure that this change in casemix has brought into the service is a safety issue as well as a challenge for operational performance and budgets. Different ambulance services have responded in different ways to broadly the same changes to the pattern of demand.

As with operational performance there is a broad consensus on the developments in clinical practice that are required in order for services to respond to changing clinical demands on a sustainable basis. In summary these developments comprise:

I. Consistent implementation of the new models of care best summarised in the AACE vision document Leading the Way to Care (2015).

II. Staff support and development to provide capacity and capability to implement this vision.

III. Deployment of digital technology, (eg directory of services, care records, e-referral, patient tracking and blue tooth connectivity of clinical devices), to support these new care models in a clinically productive way.

3. WORKFORCE

Ambulance services face very considerable workforce pressures. These must be resolved in order for the services to have a sustainable future. There is a current shortfall in the supply of paramedics which is likely to increase even after taking account of a recent expansion in paramedic training programmes. The grading for paramedics needs to be resolved nationally, supported by role development and adequate resourcing. There is also a major challenge to address in staff engagement, leadership and productivity.

The action required to address these challenges will need to be effective right across the country. National work is underway to address the banding issue and (through HEE) to increase paramedic supply. More paramedics will still be required and recent improvements in some workforce indicators will need to be accelerated and extended universally.

4. FINANCE

The financial context for ambulance services is becoming much more challenging. Income has risen steadily in recent years, but commissioners plan to reduce investment going forward and there are additional risks around CQUIN. Four out of the ten ambulance trusts are now in deficit and all face significant cost pressures including paramedic grading, IT and NHSLA requirements. At the same time the challenge of transformation will require significant direct costs and entail the opportunity costs of focussing management effort in these areas.

Ambulance trusts will therefore need to address current pressures, the costs of transformation and other cost pressures within a shrinking financial envelope. The aggregated plans of ambulance trusts do not provide a solution to these various pressures as things stand. This challenge will require a significant reduction in overheads and average costs. It will be important to understand better the variation between costs and funding levels across the ten ambulance trusts. Moving to a national contract specification, (with appropriate variation for rurality etc) would also help to level the playing field and generate a clearer picture of where opportunities and pressures sit.

5. Organisational Development

The review group considered that the challenges identified above in relation to demand and capacity, operational performance, clinical practice, workforce and finance would not be addressed across the country by the plans already in place. In some areas, (eg. operational performance and clinical practice), there is considerable agreement across all stakeholders what action needs to be taken, but plans are not yet in place to deliver these improvements. In other areas, notably finance, there is not yet a clear view of what needs to be done across the sector.

All were agreed that addressing these challenges would require significant organisational development and potential reconfiguration across the ambulance service. A range of options was considered in outline, summarised in the table below:

	Options	Positives	Negatives
1	**Do nothing**	• No distraction from organisational change	• Does not address key sustainability challenges facing ambulance services
2	**Do minimum** Provide more national guidance	• No distraction from organisational change • Could address variation in practice and procedure across ambulance services • Could be incorporated within commissioning guidance	• Unlikely to have sufficient momentum to address key sustainability challenges facing ambulance services at the pace required. • Individual trusts could opt out
3	**Structured collaboration** Link with ECIP collaborative	• Can be directed at any of the challenges identified in this review • Further opportunities for improvement demand management schemes across local geographies • Enabler for the implementation of clinical hubs • Could entail commissioner participation • Avoids potential distraction of organisational change	• Can a collaborative exert sufficient authority to secure compliance where required? • There is already a plethora of networks which between them have not been able to address the challenges identified by this review.
4	**Sector alliance**	• Opportunity to do elements at scale • Has the potential to change scope and increase integration over time • Sharing resources and workload on project i.e IT implementation • Back office rationalisation • Joint tendering – i.e. service lines at scale to improve offer eg PTS	• Large geographies may limit working relationships and ability to respond. • Individual trusts could opt out. • Can this approach address the scale of challenge at the pace required?
5	**Re-drawing boundaries**	• Alignment with transformational boundaries, eg STPs • Alignment with patient flows • Address cross boundary issues • Limited organisational change.	• Does not address key sustainability challenges facing ambulance services

6	**Consolidation or chain** Options include consolidating ambulance services from 10 to 4 or 1.	• Able to reduce variation and implement standard operational models. • Secure the scale necessary to deliver major change • Stronger voice for ambulance services within NHSI & NHSE • Could address some STP boundary issues	• Time and effort required to establish new governance and operating arrangements could be a significant distraction and constrain the pace of change. • Local Political support may be lacking – eg elected mayors. • Potential for dislocation from other organisational development, eg STPs and devolution • Large geographies may limit working relationships and ability to respond and engage will staff. • Reduced ability to support local network and support integration of services.
7	**Tri-service integration**	• Options to share estate costs • Improved response to major incidents	• Limited interaction with the fire service (2% of activity) and police (10% of activity) • Limited examples/ case studies that it works • Managing health priorities over police.
8	**'Retreat to trauma'** reduce scope of ambulance provision	• Improved ability to manage demand • Maintaining trauma skill set	• Does not address core issues • Would need a separate provider to be commissioned for urgent care.
9	**All urgent and emergency care in a single organisation (UEC Trusts)**	• Significant increase in scale from individual ambulance trusts. • Potential benefits of working in a single organisation with other parts of the UEC system.	• Major distraction of organisational change on this scale. • Footprint of individual ambulance provision (and therefore critical mass required for operational efficiency) likely to be decreased from current ten ambulance trusts. • Lack of evidence on which to base such a model. • Likelihood of unintended consequences for other services, (eg losing integration of emergency, acute and elective provision across key services/specialties such as cardiology)
10	**Accountable Care Organisation** Geographical or sector based	• See options 6 (for sector ACO, ie single ambulance trust with commissioning responsibilities) & 9 (for geographical patch ACO incorporating all UEC responsibilities)	• See options 6 & 9

These options were considered in outline only. They are not mutually exclusive and could be considered in combination. Further work is needed to develop the options but nonetheless some key themes emerged from the discussion:

- Do nothing and do minimum options were considered to be very unlikely to be able to meet the challenges to be addressed.
- Collaborative models offer the potential for consolidation of effort without the distraction of major organisational change. To be successful there needs to be an ability to gain traction universally and not allow disengagement, opting out or settling on the lowest common denominator.
- Organisational consolidation has the potential to secure the changes required. However, the process of merger or assembling a chain would consume a great deal of time and effort that could be a distraction from key changes required.
- Other forms of organisational change, including tri-service integration, have interesting features to them but do not offer a compelling response to the challenges identified in this review.

Further consideration of options for organisational development and configuration is required. The review group's recommendation is that this focuses principally on options 3, 4 and 6 above.

In attendance:

- Miles Scott, NSHI (Chair)
- Dave Ashford, NSHI – ECIP
- Leon Bardot, NAO
- Poppy Bragg, NHS Clinical Commissioners
- Helen Brooks, NSHI – workforce
- Derek Cartwright, NWAS
- Helen Daly, NHSE
- Daniel De Rozarieux, NSHI - South
- Mark Ellis, NHSI – ECIP
- Martin Flaherty, AACE
- Nick Hall, NHSE
- Will Hancock, SCAS
- Nick Hardwick, NHSI – Midlands and East
- Sharon Harrison, HEE
- Anthony Marsh, WMAS
- John Martin, NHSE & College of Paramedics
- Yvonne Rispin, Blackpool CCG & NHS Clinical Commissioners
- Owen Southgate, NHSI – North
- Ciaran Sundstrem, NSHE
- James Vallence, DoH

Apologies:

- Jane Allberry, DH
- Jonathan Benger, NHSE
- Fabian Henderson, NHSI
- Patrick Mitchell, HEE
- Keith Willett, NHSE