Committee of Public Accounts

Written evidence from the NHS Confederation

AMBULANCE SERVICE NETWORK/NATIONAL AMBULANCE COMMISSIONING GROUP

KEY LINES ON FUTURE MODELS FOR AMBULANCE SERVICE COMMISSIONING

EXECUTIVE SUMMARY

Equity and excellence: Liberating the NHS

The coalition Government’s health White Paper, “Equity and excellence: Liberating the NHS” published on 12 July 2010 proposes significant reforms within the NHS. These include changes to the commissioning system with the establishment of an independent NHS Commissioning Board and the transfer of commissioning responsibility from PCTs to groups of GP practices working together as part of commissioning consortia.

Ambulance services and commissioning levels

Ambulance services cost around £1.5 billion each year but have an impact on around £20 billion of NHS spend on emergency and urgent care. Therefore it is essential that the commissioning models for ambulance services are right.

The White Paper does not explicitly state where the responsibility for commissioning specific ambulance service provisions will lie in the future although it indicates that GP consortia will be responsible for commissioning the great majority of NHS services. To help inform further thinking, the Ambulance Service Network (ASN) and the National Ambulance Commissioning Group (NACG) have produced this discussion paper which sets out some shared “key messages” about the future models for ambulance service commissioning for the consideration of policy makers and GP commissioners.

To deliver safe, effective and resilient care for patients whilst also being responsive to local needs and priorities, the ASN and NACG would like to propose that the different elements of ambulance service provision are commissioned at the most appropriate “levels” in the system. This could be either at individual GP consortia, by groups of consortia (multi-consortia level), nationally or “regionally” by the NHS Commissioning Board; effective collaboration between these commissioning “levels” will also be essential.

This paper sets out our thoughts on what the appropriate levels might be, as follows:

Local unscheduled care services

Specific “unscheduled but primary care” services delivered by ambulance services in conjunction with existing primary, community and social care through “see and treat” and “see and refer” services should be commissioned at GP consortia level with some elements co-ordinated between GP consortia.

NHS 111 services

The ASN and NACG welcomes the strong commitment in the White Paper to a comprehensive 24/7 urgent care system and we believe that “regionally” or lead/multi-consortia commissioning of NHS 111 will be required as part of this structure. This level of commissioning will support effective regional links between 111 and 999 calls ensuring patients receive the most appropriate service and also support the regional directory of services to underpin NHS 111.

999 services and infrastructure to enable timely responses to life threatening calls

We would urge that 999 emergency services are commissioned at “regional” level by the NHS Commissioning Board with appropriate geographic arrangements or through lead commissioning for clusters of GP consortia (multi-consortia level). The ASN and NACG believe that commissioning 999 at individual consortium level could result in a fragmented service to patients.

Emergency Preparedness services

The ASN and the NACG welcomes the proposal in the White Paper that emergency preparedness should be commissioned centrally by the NHS National Commissioning Board. We would suggest that this commissioning level should also apply to emergency preparedness services/Hazardous Area Response Teams (HART) maintained by ambulance services so they have the capacity and capability to meet major incident responses.

Patient Transport Services

The commissioning of Patient Transport Services (PTS) needs separate consideration and further work is required between PTS and emergency ambulance commissioners to ensure the interdependencies are fully understood and where appropriate maintained.

---

1 We are aware that the structure for the NHS Commissioning Board has not been formalised therefore whilst this is being determined, the ASN and the NACG has interpreted the “regional” level of commissioning to include the possibility of the NHS Commissioning Board having some mechanism for commissioning at a sub-national level.
Next steps

A robust transitional approach to ambulance commissioning over the next two years will be essential during the implementation of the new NHS reforms set out in the White Paper, as well as continued discussions with GP representative organisations to support and enable the commissioning of ambulance services at the most appropriate levels.

1. BACKGROUND AND INTRODUCTION

The Ambulance Service Network (ASN), which forms part of the NHS Confederation, is the membership organisation for the 17 NHS ambulance providers in England, Wales and Northern Ireland and the islands of Man, Guernsey and Jersey. It was established to provide a strong and independent voice for UK ambulance services, and to help ambulance services work more closely with the rest of the NHS and with other key stakeholders in health and social care.

The National Ambulance Commissioning Group (NACG) is formed from the lead commissioners for each of the ambulance services in England. It is supported by the PCT Network within the NHS Confederation. The purpose of the group is to share and develop best practice between members in order to strengthen ambulance commissioning, and to inform and influence national health policy relating to ambulance service provision and its role in and the wider emergency and urgent care system, from a commissioners’ perspective.

Following a joint event held on 1 July 2010 to examine the “future direction for ambulance services in England”, the ASN and NACG have been working together on three projects:

— informing future commissioning arrangements and service models for ambulance provision in England in light of the NHS white paper;
— developing contracts and service specifications for 2011–12; and
— developing outcomes-based performance indicators and metrics.

A clear strategy for the development of ambulance services is being developed jointly, building on the work from the National Ambulance Commissioning Group (NACG)’s paper “Achieving integrated unscheduled care” which set out the following aims:

— To contribute effectively to national, regional and local leadership of emergency and urgent care policy and delivery.
— To ensure that over the next two years, approaches to commissioning ambulance services deliver improvements in quality, efficiency and productivity while maintaining performance and stability.
— To support the development of new commissioning models that will enable ambulance service to be commissioned in future as:

(a) Part of an efficient, integrated local urgent care pathways.
(b) Effective providers of emergency care for life threatening conditions.
(c) Services that have the capacity and capability for ongoing emergency preparedness and system resilience to meet changing.

Currently there are lead commissioners for ambulance services for each of the 11 English Ambulance Trusts. These individuals have developed the skills, knowledge and experience which has delivered an improvement in the delivery of ambulance services and also brought a strategic service development direction into the commissioning process. These skills and knowledge will need to be developed in the new system.

One of the agreed outputs was a set of shared “key messages” about future arrangements for ambulance service commissioning. This paper sets out these key messages for the consideration of policy makers and GP commissioners.

It suggests that the best way to ensure the care received by individual patients using ambulance services is safe, comprehensive and resilient while also being responsive to local needs and priorities, is to organise ambulance service commissioning at several different “levels” in the system.

Ambulance services cost around £1.5 billion each year, but have an impact on around £20 billion of NHS spend on emergency and urgent care. It is therefore essential to get the commissioning models right to support Quality and Productivity in an environment of increasing demand for unscheduled care.

2. THE WHITE PAPER “EQUITY AND EXCELLENCE: LIBERATING THE NHS”

The coalition Government’s White Paper on health reform (“Equity and excellence: Liberating the NHS”) published on 12 July 2010, proposes what could be the most significant reorganisation of the NHS in its history.
A key objective of the White Paper proposals is to shift power from the centre (i.e., from national government and the department of health) to local communities, healthcare professionals and individual patients.

To achieve this, an independent NHS Commissioning Board would be established and responsibility for commissioning most health services would be transferred from PCTs to groups of GP practices working together in commissioning consortia.

The Commissioning Board would be responsible for allocating and accounting for NHS resources, promoting quality improvement and public and patient engagement, ensuring the development of the new GP commissioning consortia and holding them to account, and directly commissioning certain services.

The proposed timetable is for the Commissioning Board to be established from 2012, with the new commissioning system to be in place by April 2013, after which SHAs and PCTs (which are currently responsible for commissioning ambulance services) will be abolished.

**Implications for ambulance service commissioning**

The White Paper does not explicitly state where responsibility for commissioning ambulance services would lie in future. It indicates that GP consortia will be responsible for commissioning the great majority of NHS services, including urgent and emergency care, but that the Commissioning Board will directly commission some services that cannot solely be commissioned by consortia, and can host commissioning networks with consortium agreement.

In light of this, the ASN and NACG have been working together to consider how the commissioning of ambulance services might work in the new system, and what they can do to help new commissioners in both the Commissioning Board and the consortia to put effective arrangements in place.

We hope that outcomes of debate on this issue between existing commissioners and providers will be of interest to both current policy makers and future commissioners, and will therefore help to ensure that safe, effective and efficient models for commissioning ambulance services are established by 2013.

### 3. Ambulance Services and Commissioning Levels

Ambulance Services have developed considerably from the days when their only response was to transport patients to hospitals, Trusts now have non-conveyance rates (i.e., cases where they deal with calls and incidents over the phone, on-site, or by referral to alternative appropriate services) of between 30% and 50%. As a result of the implementation of local “see and treat” and “see and refer” services, the role of ambulance providers, and the skills and competencies of their staff, has changed significantly.

It is recognised that the pace of development and transformation between Ambulance Services has differed across the country; overall there is clear strategic alignment on the direction of travel. Whilst this is not purely down to commissioning arrangements, there is a link with level of strategic engagement by commissioners.

Arrangements for commissioning ambulance services have also evolved in recent years. To reflect the reorganisation of NHS Ambulance Trusts in England onto (broadly) regional footprints, ambulance commissioning is likewise organised on a regional (SHA) basis with a lead commissioner acting on behalf of all the PCTs in the health authority area. These lead commissioners are responsible for agreeing strategic plans, priorities and funding across all of their constituent PCTs, and translating these into contracts and specifications for commissioning services from the ambulance trusts.

Both the ASN and the NACG acknowledge that in some areas ambulance commissioning has focussed too much in the past on transactional contract and funding negotiations at the expense of more strategic work to redesign and modernise service provision. However, this has begun to change as the current set of commissioner and provider organisations have matured.

Some of the critical learning from this experience has been the need to acknowledge and find ways of handling the tensions between those factors that drive ambulance services to operate in a highly standardised and structured way across large geographical footprints (in particular the need for service scale and command chains that enable rapid, unambiguous and expert responses to major incidents and emergencies) and those that demand a more localised, tailored, and flexible approach to service delivery (including the need for effective integration of ambulance services into local health systems which can vary significantly from area to area).

Based on their recent experiences of confronting these issues while building effective commissioning relationships, ASN and NACG members would like to propose that GP consortia and the NHS Commissioning Board consider the different elements of ambulance service provision described below, and the relationships between them, when agreeing new commissioning arrangements. In addition, consideration needs to be given to the role of the Local Authorities.

We believe that these different elements are most appropriately commissioned at different levels, either by individual GP consortia, by groups of consortia (multiconsortia level) nationally or “regionally” by the NHS Commissioning Board, but that the interdependencies between them mean that effective communication and collaboration between commissioners at these different levels will be essential.
A robust transitional approach to ambulance commissioning will be required over the next 12–30 months to ensure that the NHS gets the value for every tax payer pound.

This paper sets out our thoughts on what the appropriate levels might be, as follows:

1. **Local unscheduled care services delivered in conjunction with existing primary, community and social care (including “see and treat” and “see and refer” services delivered in the home, GP surgeries or other out of hospital environments)**

   Responsive ambulance services that can initiate an effective emergency response, but that are well integrated with unscheduled but non-emergency care are critical to the efficiency of local health systems. Although this is not necessarily the commonly understood core business of ambulance services, in reality a significant volume of ambulance work involves dealing with non-life threatening conditions, and incidents that do not require specialist or acute care.

   The ability of ambulance service professionals to communicate with, refer into, and provide services alongside appropriate local non-emergency services—and in doing so to convert “inappropriate” demand for emergency services—is therefore vital to effective demand management. The role of ambulance service professionals has become increasingly important here in recent years with the implementation of “see and treat” and “see and refer” services.

   As they are embedded in local unscheduled care systems, we would argue that specific “unscheduled but primary care” services provided by ambulance services but designed to support particular care pathways and service models should be commissioned at GP consortium level. Many ambulance services already provide specific primary care support to local GPs including enhanced roles for paramedics and also provide extended urgent care services such as GP out of hour’s services.

   Because in operational terms these local primary services cannot be entirely separated from an ambulance provider’s emergency response service, some elements would need to be co-ordinated between consortia, including:

   - Strategic direction and advice—including understanding patterns of activity and demand and service pressures and gaps, reflecting on ambulance specific data.
   - Co-ordination of commissioning plans—to ensure that local strategic directions for urgent care have sufficient consistency to manage patients across boundaries.
   - Liaison with the national urgent and emergency care work.
   - System/pathway wide management of the interface eg hospital handover and capacity issues.

2. **NHS111 services based around the responses where high quality triage is the precursor to referral of patients to the most appropriate service which may or may not involve an ambulance response or transfer to hospital**

   The ASN and NACG welcomes the strong commitment in the White Paper to a comprehensive 24/7 urgent care system. The development of the three digit urgent care number is already beginning to show benefits and the relationship with out of hour’s providers in some areas is well established. Ambulance Services have a central role in the further development and implementation of the new NHS111 system and in turn improving local urgent and emergency care systems through the telephony based triage system NHS Pathways/Directory of Services and the Single Point of Access.

   We believe that “regional” or lead/multi-consortia commissioning of NHS111 will be required to ensure that:

   - Costs are kept to a minimum and the most effective and efficient service can be delivered in terms of call handling and telephone triage using NHS Pathways so that patients get a consistent and evidence based response to their calls. This will include the development and monitoring of appropriate resilience and clinical governance arrangements across all single point of access (SPA) providers.
   - Effective regional links can be developed and maintained between 111 and 999 calls to ensure that patients are referred to the most appropriate service including an emergency ambulance response.
   - The directory of services underpinning NHS 111 is developed and maintained in the most efficient way ie that the maintenance of one directory covers as complete a geographic footprint as possible whilst giving full and real time local information.
   - That feedback enables local commissioners to have informed discussions about the effectiveness of urgent and emergency care for their local population, even where patient decisions/destinations cover a wider geographic area than that normally covered by the consortium.
   - The data generated from 111 calls is quickly used to inform GP commissioning consortia of changes in levels of demand, appropriateness of local service offer and patient experience and outcomes measures.
3. 999 services and the infrastructure to manage calls where a speedy response is needed to life threatening individual incidents

The ASN and NACG would urge that 999 ambulance services are commissioned at a “regional” or lead/multi-consortia level. We would be concerned that commissioning at an individual consortium level would run the risk of fragmenting the service response, reducing resilience and confusing mutual aid arrangements, vital to retain resilience if individual regions are excessively pressured eg in adverse weather etc. Currently incidents are charged to the geographic location rather than linked to the patients GP. This needs to be taken into account.

The ASN and NACG believe that there are, during the transition to a fully GP led commissioning system, advantages to having stable, experienced and high quality providers of emergency ambulance services working across the regions to continue to manage demand and improve specialist services eg trauma networks.

Regional or lead commissioning for 999 services would:

— Provide a co-ordinating role for formal contract and performance management of ambulance providers across the large geographical footprint needed for 999 services whilst providing outcomes information for each GP consortium.

— Provide a co-ordinating role with local GP consortia within the region in the development of a regional integrated unscheduled care strategy to ensure high quality emergency 999 service coverage and a continued emphasis on the management of demand.

— Enabling local GP consortia to collaboratively set the commissioning intentions balancing the need for regional consistency and appropriate localization.

— Aid the further development of specialist pathways for stroke, trauma, cardiac and vascular services etc.

— Avoid the risk of cutting across the good, clinically evidence work of joining up specialist pathways eg for stroke, trauma, heart attacks which have a regional focus.

— Aid regional pathway initiatives for example around big cities for particular patient groups.

— Enable patient, public and stakeholder engagement in the strategic model for urgent and emergency care.

4. Emergency Preparedness services (HART, CBRN) and response to major incidents, terrorism etc

The White Paper has acknowledged that emergency preparedness should be the responsibility of the National Commissioning Board. The ASN and NACG support this proposal, and suggest that ambulance services related to maintaining emergency preparedness should, accordingly, be specified and commissioned centrally by the NHS Commissioning Board.

We would emphasise that this needs to include all elements of emergency preparedness including ensuring interoperability of equipment, control room resilience, mutual aid, and funding for Hazardous Area Response Teams (HART) to ensure that the current system is developed further and is resilient in times of need.

Although the planning of emergency preparedness should be managed nationally, it is important to recognise relationships and interdependencies between these and more routine but still emergency 999 ambulance services, and the operational implications of this for ambulance service providers.

OTHER NATIONAL REQUIREMENTS

In addition to maintaining emergency preparedness, there are also other situations where a nationally co-ordinated response is required. An example at the moment is the planning, coordination and delivery of adequate ambulance service provision during the 2012 Olympics.

As national services, we believe these should also be commissioned centrally at a national level. It will be important to ensure that locally developed ambulance commissioning plans and specifications take into account the need for ambulance providers to respond effectively and efficiently to these national requirements, and do not prevent them from doing so.

5. Patient Transport Services (PTS)

The commissioning of Patient Transport Services needs separate consideration. Whilst all NHS Ambulance Trusts provide PTS to some extent, it is a service area with a large number of private and third sector providers. The CQC will be regulating providers and the standard ambulance contract must be used for contracting for PTS. There must be specific requirements to ensure the resilience of the emergency ambulance service is supported and also that the Civil Contingency Act requirements are met. Further work is needed between PTS and emergency ambulance commissioners to ensure the interdependencies are fully understood and, where appropriate, maintained.

Another area for commissioners to consider is the potential for commissioning integrated health and social care patient transport services, particularly in rural areas.
These levels for the different types of service can be shown in the following diagram. This builds on the individual patient and practice level commissioning responsibility that all GPs already hold to ensure the patient is at the centre of their own care.

**Commissioning Levels**

- **Individual GP Consortia**
- **“Regional” or Lead Multi-Consortia**
- **NHS Commissioning Board**

**Ambulance Provisions**

- 1. Unscheduled primary care
- 2. NHS 111
- 3. 999 services
- 4. Emergency preparedness
- 5. Patient Transport Services (PTS)

Regional links between NHS 111 and 999 calls

Interdependency between more routine but still emergency 999 and emergency preparedness and 999 calls

**Development of the Commissioning Model**

The NACG and ASN are continuing to work together to develop and build on the standard contract to support greater consistency in the service specifications. This includes the development of the currencies to support Payment by Results for ambulance services.

Specific work on the mechanisms to attribute ambulance patients to a responsible commissioner needs to be addressed if GP consortia are to be able to manage their patients care across the whole emergency & urgent care system.

The development of indicators to support the outcome framework is already underway, with providers and commissioners involved in the Ambulance Response Time Working Group.

The strategic direction and models of service are also being jointly developed. This provides clarity of direction for the providers as well as GPs and NHS Commissioning Board as the new model for commissioning is established.

Early discussions with the ASN and the BMA and RCGP suggest that a development plan should be produced to support and enable effective commissioning of the appropriate levels of ambulance service by GP consortia.

To support the management of commissioning during the transition, including delivering QIPP, the ambulance commissioners are considering proposing options for a transitional team to more formally organise their current informal shared working arrangements.

**Conclusion**

The document provides a discussion paper to encourage the consideration of the best commissioning model to ensure that care received by individuals using ambulance services is safe, comprehensive and resilient while also being responsive to local need and priorities.

*September 2010*