Urgent & Emergency Care Transformation

NHS England Guidance Documents

Key Reference Points for

NHS Ambulance Services

January 2016

This document is intended as a quick guide to locate references to some of the key national objectives or recommendations from NHS England regarding the transformation of urgent & emergency care delivery particularly in relation to the role that NHS Ambulance Services have in this. It has been put together to assist those involved in strategy planning and development of business cases in linking their activities and proposals to national aims. The list is not exhaustive but focuses on some of the key aspects in delivering transformation.

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	Urgent & Emergency Care Transformation - NHS England Guidance Documents	
Abbreviation		Date Issued
UECR	**Transforming urgent and emergency care services in England : Urgent & Emergency Care Review Phase 1 Report** http://www.nhs.uk/nhsengland/keogh-review/documents/uecr.ph1report.fv.pdf	Nov-13
FYFV	**Five Year Forward View** https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf	Oct-14
SFB	**Safer, faster, better: good practice in delivering urgent and emergency care** https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf	Aug-15
HIA	**NHSE letter to SRGs including High Impact Actions for Ambulance Services** https://www.england.nhs.uk/wp-content/uploads/2012/10/winter-readiness-letter-1516.pdf	Aug-15
IUCCS	**Integrated Urgent Care Commissioning Standards** https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf	Sep-15
CMAS	**Clinical models for ambulance services** http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR-ambulance-guidance-FV.PDF	Nov-15
IRP	**Improving referral pathways between urgent & emergency services in England** http://www.nhs.uk/NHSEngland/keogh-review/Documents/improving-referral-pathways-v1-FINAL.PDF	Nov-15
	Other Useful Documents	
	Vision for the ambulance service: 2020 and beyond http://aace.org.uk/wp-content/uploads/2015/09/Ambulance-2020-and-beyond-the-AACE-vision.pdf *Association of Ambulance Chief Executives (AACE)*	Sep-15
	NHS Ambulance Services - Leading the way to care - AACE http://aace.org.uk/wp-content/uploads/2015/10/AACE-Leading-the-way-to-care-FINAL-W.pdf *Association of Ambulance Chief Executives*	Oct-15
	Good practice in ambulance commissioning http://www.nhscc.org/wp-content/uploads/2015/06/Good-practice-in-ambulance-commissioning-final-pdf-for-website-1.pdf *The National Ambulance Commissioners Network - NHS Clinical Commissioners*	Jun-15

	NATIONAL OBJECTIVE / RECOMMENDATION	REFERENCE
	ACCESS - COORDINATION OF RIGHT RESPONSE, RIGHT PLACE, FIRST TIME - **"We must help people with urgent care needs to get the right advice in the right place, first time"**	
Access - Coordination of Right Response, Right Place, First Time	Significantly enhance NHS 111 so that it becomes the smart call to make, creating a 24-hour, personalised priority contact service, which will…Have knowledge about you and your medical problems, so the staff advising you can help you make the best decisions. Clinicians in the new NHS 111 service will have access to relevant aspects of your medical and care information,...Allow you to speak directly to a wider range of professionals (e.g. a nurse, doctor, paramedic, member of the mental health team, pharmacist or other healthcare professional)...If needed, directly book you an appointment at whichever urgent or emergency care service can deal with your problem, as close to home as possible...Still provide you with an immediate emergency response if your problem is more serious, with direct links to the 999 ambulance service, and the enhanced ability to book appointments at Emergency Centres.	UECR: p23, p24
	Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists. Strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.	FYFV: p21, p22
	Helping people who need urgent care get right advice, right place, first time. CCGs, SRGs and UECNs should develop a functionally integrated service, incorporating NHS111, OOH and collaboration with ambulance services…to provide patients with an enhanced urgent care treatment and advice service with a SPOA for all health and social care urgent calls. Co-located services should actively encourage transferred patients (from 111) to use the service best suited to their needs rather than defaulting to emergency departments AS should maintain clinical hubs in their EOCs to ensure appropriateness and timeliness of responses...staffed by range of clinicians.	SFB: p6, p24, p30, p31, p37
	All services to progress Clinical hub development – with wider MDT and specialist input. The expertise accessible through an urgent care clinical hub, on a 24/7 basis, could include (but is not limited to): pharmacy; dental; midwifery; mental health crisis and liaison psychiatry; end of life care; respiratory (including COPD); paediatrics; care of the elderly; drug and alcohol services; social care; secondary care expertise including general medicine and general surgery.	HIA: 1

	An Integrated Urgent Care service, supported by an Integrated Clinical Advice Service (Clinical Hub) will assess the needs of people and advise on or access the most appropriate course of action, including: - Where clinically appropriate, people who can care for themselves will be provided with information, advice and reassurance to enable self-care. - Where possible people will have their problem dealt with over the phone by a suitably qualified clinician. - People requiring further care or advice will be referred to a service that has the appropriate skills and resources to meet their needs. - People facing an emergency will have an ambulance dispatched without delay Ambulance services should have the facility to electronically transfer patient details to Integrated Urgent Care for early clinical assessment if the call is assessed as a green disposition rather than being required to deal with the call themselves. The Clinical Hub should serve two purposes: to provide clinical advice to patients contacting the 111 or 999 services, as well as providing clinical support to clinicians (particularly ambulance staff such as paramedics and emergency technicians) to ensure that no decision is made in isolation. It could also support the wider Urgent Care Network (for example nursing and residential homes and other emergency services such as the police, for use in street triage). We would encourage the joint commissioning and establishment of hubs and at an appropriate scale – avoiding overlap and duplication. Over time additional methods of communication and support (for example video- consultation) should be explored to further increase the effectiveness of the clinical hub.	IUCCS: p11, p20, p22

	Commissioners may find it helpful to consider the clinical needs and transportation requirements of the patient as two separate entities, each of which must be met by an integrated service. Modifications to the current time-based ambulance standards, and approaches to transport asset deployment, may be required to support this move towards a more clinically focussed model, and are also under consideration. In the meantime commissioners should include contractual incentives and/or contract monitoring information that reflect these new ways of working. Closer working between existing NHS 111 providers (and emerging Integrated Urgent Care providers), mental health crisis lines and 999 will be supported by the increasingly widespread use of Clinical Decision Support Systems (CDSS), to provide a consistent process of assessment and determining dispositions. This has a number of potential benefits: Seamless re-direction of the patient to the most appropriate service, regardless of the initial number called. This provides a consistent response and allows a more efficient use of resources; More effective feedback and enhanced learning between the services, building mutual trust and reducing the number of unnecessary ambulance responses; Sharing of resources (for example call handling and clinical advice) to more effectively manage peaks in demand, whilst improving consistency and efficiency. In many cases commissioners may find that co-location of Integrated Urgent Care (including NHS 111 contact centres) and 999 services may enhance the benefits described above. Additional integration may yield further benefits and commissioners may wish to consider which configurations will work best in their areas, possibly across wider urgent care networks. To support effective hear and treat, as well as ambulance staff at scene, it is recommended that commissioners include the urgent care clinical hub described above in specifications. To improve working relationships, dialogue and feedback the clinicians that make up this hub may be physically located in the same place and provide a 24/7 presence. For clinical specialties and expertise which is consulted less frequently it may be more appropriate to make arrangements to contact an individual who is off site through the creation of a “virtual urgent care clinical hub”.	CMAS: p12, p14, p16

	NATIONAL OBJECTIVE / RECOMMENDATION	REFERENCE
	SUPPORTING SELF-CARE - "We must provide better support for people to Self-Care"	
Self-Care	Our starting point must be to equip as many people as we can with the skills, knowledge and support needed to self-care. This is by far the most responsive way of meeting people's urgent but non-life threatening care needs...To achieve this, we will need to: Provide much better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional.	UECR: p22
	The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff e.g. CFRs. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes.	FTFV: p13
	Providing better support for people and families to self-care or care for their dependants. Supporting people to manage long term conditions	SFB: p6, p18,
	Anonymised aggregate information from ambulance services can also be used to support prevention and public health, for example by targeting drug and alcohol problems. For example, ambulance services can identify and refer patients, with their consent, to drug and alcohol services and could be trained to use tools such as Identification and Brief Advice (IBA) for a range of public health issues, including injury and alcohol.	CMAS: p13

	NATIONAL OBJECTIVE / RECOMMENDATION	REFERENCE
	OUT OF HOSPITAL URGENT CARE – **"We must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E"**	
Out of Hospital Urgent Care	Providing responsive urgent physical and mental health services outside of hospital every day of the week. Where safe & efficient to do so…good practice to bring care to the resident in the care home. Ambulance Service & CCGs should develop mobile urgent treatment service capable of dealing with more people at scene and avoiding unnecessary journeys to hospital. Care delivered by senior clinical decision makers (such as specialist or advanced paramedics/nurses) produces better clinical outcomes and can reduce demand for emergency ambulances for non-critical 999 calls through see& treat or referral to community services or other pathways	SFB: p6, p25, p31
	Commissioners should utilise UCCs, staffed by a multi-disciplinary team, and ensure that these accept patients conveyed to them by ambulance under agreed guidelines and care pathways. Contracts should reflect that the emphasis should be on appropriate assessment and acceptance (with its associated value to the system and patients) rather than a default current position of conveyance to A&E. Transportation of patients with urgent care needs, following assessment by a GP or other Allied Health Professionals (AHP), does not always require the presence of a paramedic. Consideration should be given to alternative commissioning arrangements for this type of service to avoid inappropriate use of resources, including co-responder schemes where appropriate To be effective, see and treat models require the commissioning of two distinct components: i) Skilled assessment, diagnosis and treatment at scene: This will be achieved by educated and equipped practitioners; usually a paramedic with specialist or advanced skills but potentially also other healthcare professionals...These practitioners will also be supported by peers and specialists accessible through the urgent care clinical hub, ii) A range of treatment and referral options (ideally including independent prescribing) that are consistently available and accessible in a time frame that is consistent with the patient's needs and expectations. Commissioners should be aware of the potential for the ambulance service to become an integral component of an overall urgent care system that provides "wrap-around" integrated care in community-based settings. Successful commissioning of this type of approach will require awareness of the flexibility and overlap in the skills and functions of staff, crossing traditional organisational and professional boundaries. Commissioners will need to work with colleagues across the system to ensure that contractual models encourage this type of working and there are no perverse incentives within payment mechanisms.	CMAS: p11, p12, p17, p18

	By supporting and developing paramedics, and providing direct access to the expertise of general practitioners and specialists, around half of all 999 calls which require an ambulance to be dispatched could be managed at the scene, avoiding an unnecessary trip to hospital. However, there is a great deal of variation around the country in the number of paramedics available, access to GPs and the frequency with which patients are transported to hospital. This must be improved so that ambulances can become and are seen as a community-based mobile urgent treatment service, rather than solely a means of transportation. Provide faster and consistent same day, every day access to primary care and community services for people with urgent care needs. This is likely to mean general practice, out-of-hours services, community health teams and the NHS 111 service working together, and differently, to ensure that patients with urgent care needs can receive prompt advice and care 24 hours a day, seven days a week. There are many innovative options to explore. The evidence for prompt telephone consultations is compelling, and can free up appointments to spend with those patients who would benefit from face to face care. Develop 999 ambulances so they become mobile urgent treatment services, not just urgent transport services. We know that paramedics can now deliver treatments that would only have been done by doctors 10 years ago, whilst with the support of improved community services they can safely manage many more people at scene. This gives us both more options to treat people at home, and to travel further to reach specialist care. There are opportunities for extending paramedic training to better assess, prescribe for and manage patients with exacerbations of chronic illnesses and work more closely with GPs and community teams.	UECR: p19, p24, p25

	NATIONAL OBJECTIVE / RECOMMENDATION	REFERENCE
	EMERGENCY CARE -"We must ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery"	
Emergency Care	Introduce two levels of hospital based emergency centre…These two levels will only be introduced once access to urgent care services outside of hospital have been sufficiently improved and enhanced, and in time will replace the inconsistent levels of service currently provided by A&E departments. Develop emergency care networks. The recent introduction of major trauma networks has been a huge success story that has saved the lives of hundreds of patients. Support the introduction of an efficient critical care transfer and retrieval system…to ensure that patients with specialist needs reach the best possible care in a timely fashion...	UECR: p25, p26
	Ensuring adults & children with serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise	SFB: p6

	NATIONAL OBJECTIVE / RECOMMENDATION	REFERENCE
	DEMAND MANAGEMENT	
Demand Management	Balancing capacity and demand along the pathways. Managing interfaces and handovers. Managing seasonal pressures Escalation plans Minimise handover delays	SFB: p10, p13, p19, p20, p32
	For patients who do need to be taken to hospital, ambulance services should minimise handover delays by: • Reviewing patients' conditions and needs en-route and sending details ahead to the receiving emergency department in the case of any special requirements/circumstances. • Avoiding the use of ambulance trolleys for patients who are able to walk into the department. • Using alternative vehicles to convey patients to the emergency department (e.g. patient transport service vehicles to transport patients, thus keeping paramedic staffed ambulances available. • Implementing electronic patient handovers. • Sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation when demand rises.	HIA: 9
	Integrated Urgent Care providers must ensure that their capacity planning is conducted in liaison with other healthcare providers who may be affected by their outputs (e.g. out of hour's providers, ambulance services, ED departments)	IUCCS: p27

	NATIONAL OBJECTIVE / RECOMMENDATION	REFERENCE
	REFERRAL PATHWAYS - **"We must connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts"**	
Referral Pathways	Connecting all UEC services together so the overall physical and MH and social care system becomes more than just the sum of its parts. Local health communities should work collaboratively with AS to develop and evaluate alternatives to conveyance to hospitals inc pathways to UCCs; referral direct to hospitals specialities, MH triage teams, Falls partnerships etc. Frail & vulnerable people - best practice to identify patients with frailty syndromes in the community and provide appropriate support...develop vulnerable patient group pathways and processes	SFB: p6, p32, p46
	Improving access to community health and social care rapid response, including falls services: Ambulance services should have (or have plans to put in place) direct access to these services, through simple routes of referral (e.g. a single point of access for professionals/single phone call) as an effective alternative to A&E conveyance and/or hospital admission. Registered healthcare professionals in the employment of ambulance services (e.g. paramedics and nurses) should be empowered and supported to refer patients that they have assessed in person to all other components of the urgent and emergency care network. This includes referral to primary care and hospital-based expertise, combined with conveyance to non-A&E destinations including urgent care centres, assessment units and ambulatory emergency care units.	HIA: 2, 3
	Commissioners will need to ensure that referral pathways include deferred referral with appropriate safety netting, as well as a requirement for the appropriate integration of electronic records and electronic referral of clinical information being present in contracts; in some cases this may be combined with the use of telemetry and telemedicine. Clinicians working in the 999 system – through 'hear and treat' or 'see and treat' models - should have unrestricted referral rights to all other services in the UECN, including social care services, with free flow of information and feedback. In rural areas, where journey times to hospital are long, effective see and treat is particularly important, and highly valued by patients. Commissioners will want to consider that additional investment in rural areas may prove particularly cost effective, with paramedics based at UCCs in remote communities, and working as an integral part of the local urgent care system (e.g. with general practitioners both in and out of hours, community nursing teams and social care).	CMAS: p11, p13, p17

	In order to facilitate an improved flow of patients and information within the UEC system, all registered health and social care professionals within physical and mental health, following telephone consultation or face-to-face contact with a patient, should be empowered, based on protocols developed and agreed locally, to make direct referrals and/or appointments for patients with: - The patient's registered general practice or corresponding out of hours (OOH) service; - Urgent Care Centres; - Emergency Departments in Emergency Centres and in Emergency Centres with Specialist Services; - Mental health crisis services and community mental health teams; - Specialist clinicians, if the patient is under the active care of that specialist service for the condition which has led to them accessing the urgent and emergency care system. It is suggested that governance and responsibility rests with the referring practitioner until the referral has been accepted by the receiving practitioner, at which point governance and responsibility transfers. To facilitate a process of continuous quality improvement, and to provide education for those who refer, an enhanced feedback loop should be established [within referral pathways]. This will provide the practitioners who receive referrals with access to a method of feeding back to a named practitioner in the referring service. To achieve this, a senior member of clinical staff with clinical governance responsibilities should be nominated in each referring service (e.g. ambulance trust, NHS 111 provider, etc.) to act as an accessible point of contact for collating and responding to this feedback, and introducing any education and system changes that are required in response to the feedback received. In some instances a "trusted assessor" model may be implemented that, by pathway, provides senior clinical expertise and authority to support practitioners operating within that care pathway and also offers expert clinical assurance for practitioners, patients and relatives. This will help to build confidence in the enhanced referral pathway, and ensure it can be subject to regular audit and review.	IRP: p10, p15

	NATIONAL OBJECTIVE / RECOMMENDATION	
	COLLABORATIVE CARE INITIATIVES	
Collaborative Care	Enhanced working with community mental health teams: Ambulance services should work with SRGs, commissioners, community mental health teams and other system partners to mental health teams improve access to early triage and assessment by mental health professionals following referral from the ambulance service. This should be supported by timely access to crisis care at home and in community-based settings. Enhanced working with primary care: consideration should be given to paramedic practitioners undertaking acute home visits on behalf of GPs, to avoid unnecessary admission and admission surges; 'call back' schemes whereby in-hours and out-of-hours primary care staff follow-up patients who have been managed at home and not transported by ambulance clinicians (within agreed time-frames); joint planning with GPs and other relevant system partners (e.g. acute trusts) to agree management plans for high-volume service users/frequent callers. Increased use of alternative vehicles to convey patients: Ambulance services should consider the use of alternative vehicles to transport patients, whenever it is safe and appropriate to do so, thereby freeing up and improving the availability of "front line" ambulance resources.	HIA: 4, 5, 8
	Patients in mental health crisis ideally should be conveyed to 24/7 mental health referral assessment units, including health-based Section 136 suite/place of safety. These may be stand-alone facilities, or co-located with other facilities. Ambulance teams will need access to live information about the current availability of local 136 suites and crisis houses, their contact details and information regarding the patients they can accommodate, such as children or patients with disabilities. Commissioners should work with police and ambulance services and others to develop appropriate capacity for assessment and conveyancing in line with the Mental Health Crisis Care Concordat.	CMAS: p11, p19

	NATIONAL OBJECTIVE / RECOMMENDATION	REFERENCE
	INFORMATION MANAGEMENT & TECHNOLOGY	
Information Management & Technology	Transform digital care…. An expanding set of NHS accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion....Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them...The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.	FYFV: p31
	Local healthcare system should work with AS to enable them to have access in real time to patient care plans. Safe, efficient patient care requires effective, timely and appropriate transfer of key information that follows the patient through the healthcare system. AS should develop plans to get access to the NHS No. through solutions such as Spine mini-services or directly.	SFB: p32, p50
	Enhanced use of information and communication technologies: This includes (but is not limited to): sharing and access to electronic patient records to support clinical decision-making; implementation of electronic patient handovers; sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation protocols.	HIA: 7
	Commissioners will need to ensure that referral pathways include deferred referral with appropriate safety netting, as well as a requirement for the appropriate integration of electronic records and electronic referral of clinical information being present in contracts; in some cases this may be combined with the use of telemetry and telemedicine. Effective urgent care services will be supported by the immediate availability of relevant patient information. UECNs should ensure that the information available to all urgent care providers (locally commissioned NHS 111, GP Out of Hours, Urgent Care Centres etc.) is optimised (in terms of access to integrated clinical records) and is also available to 999 services, including the summary care record and patient care plans.	CMAS: p11, p12

	Interoperability within the Integrated Urgent Care environment is detailed in the Interoperability Standards https://www.networks.nhs.uk/ The standards define the technical standards that must be used for the transfer of data where applicable, to and from NHS 111 application systems and the applications that integrate with NHS 111 service providers All Integrated Urgent Care applications must connect directly with the SPINE and have followed the Common Assurance Process with the ability to perform an advanced trace to obtain patients NHS Numbers. All applications must connect with the Summary Care Record to ensure access to patient records is achieved as a minimum. Integrated Urgent Care services must submit and retrieve data from the National Repeat Caller Service. Services must be capable of receiving inbound messaging that can be directed to the variety of clinical skill sets to support the online platform and also offer potential integration with 999 should that be a local requirement.	IUCCS: p36

	NATIONAL OBJECTIVE / RECOMMENDATION	REFERENCE
	WORKFORCE DEVELOPMENT	
Workforce Development	We cannot deliver the necessary change without investing in our current and future workforce Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff. Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes which international studies have shown achieve sustainable weight loss in more than a third of those who take part. Support "active travel" schemes for staff and visitors. Promote the Workplace Wellbeing Charter, the Global Corporate Challenge and the TUC's Better Health and Work initiative, and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health. The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.	FYFV: p8, p12, p14, p29, p30
	Workforce development: The development and up-skilling of the ambulance workforce (particularly paramedics) and the employment of a wider range of healthcare professionals (e.g. nurses, midwives and pharmacists) will increase the rates of both "see and treat" and "hear and treat" by enhancing the skills of the ambulance workforce	HIA: 6

	The current paramedic skill set is appropriate for the care of the overwhelming majority of this [emergency] patient group, and therefore further workforce development should concentrate on urgent care. Commissioners should be aware that staff with additional critical care skills may be required and the utilisation of specialist paramedics in critical care and of air ambulances may be considered and provision should be available. Commissioning arrangements for the future ambulance workforce will need to recognise a wider range of experience and skills, coupled with clear mechanisms for effective governance from the service in which they work, and support from a wider community of other clinicians. This includes a clear development framework through supervision and appraisal, and also the mentorship and preceptorship of newly qualified staff. No ambulance clinician should be required to make a decision in isolation, and they should work as part of an interdisciplinary team. The future clinical development of ambulance staff should place an emphasis on urgent care, with placements in primary care and mental health, and specific consideration of the frail and elderly, falls, dementia, and end of life care, self-harm, mental health crises and febrile illness in children.	CMAS: p10, p19, p20