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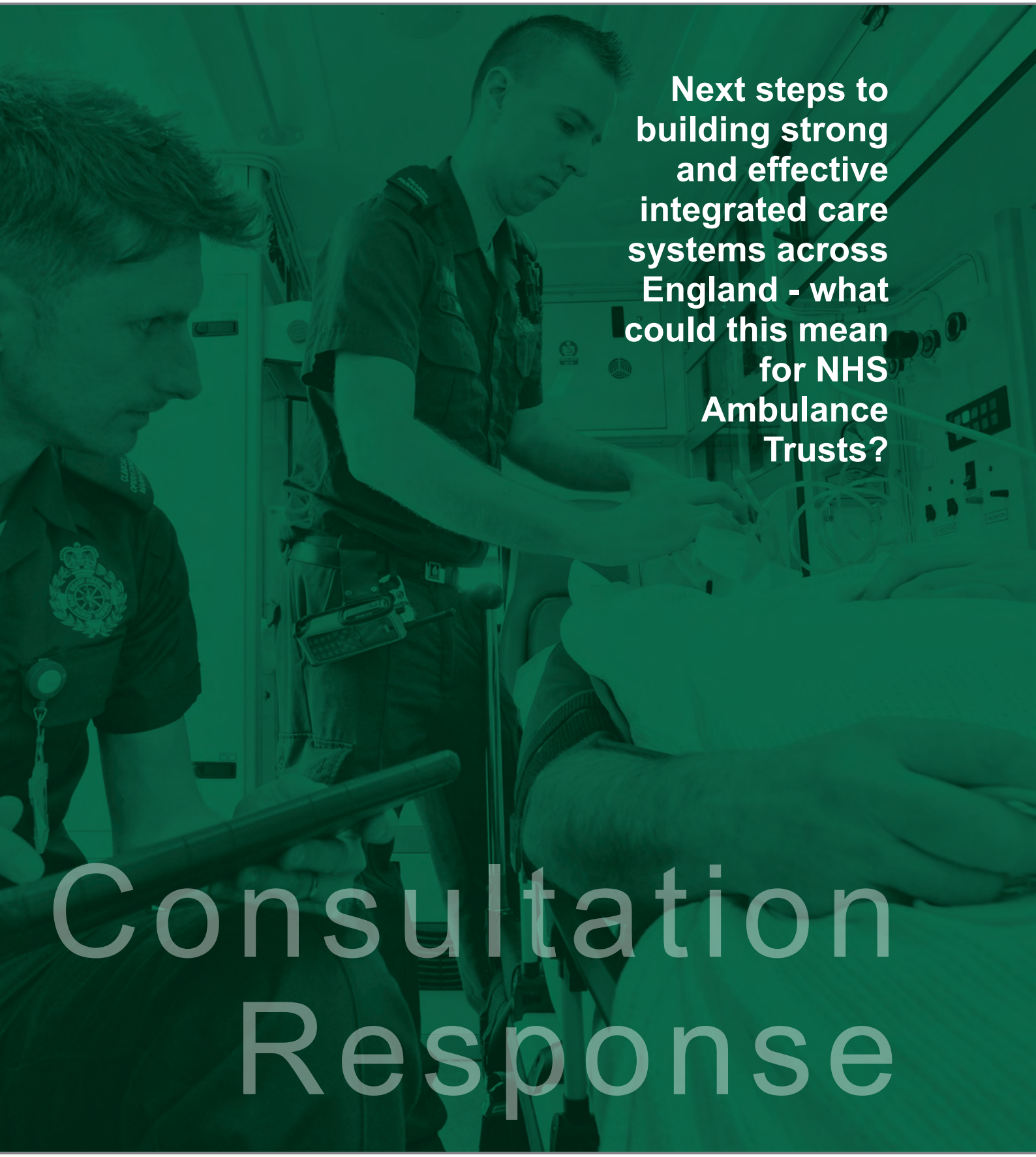

Next steps to building strong and effective integrated care systems across England - what could this mean for NHS Ambulance Trusts?

Consultation Response

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Part 1: Executive Summary

NHS England and NHS Improvement (NHSEI) have launched a consultation process inviting discussion about how Integrated Care Systems (ICSs) could be embedded in legislation or guidance.[1] This is with the aim of delivering against the NHS Long Term Plan (LTP) in supporting greater collaboration between partners in health and care systems.

The Association of Ambulance Chief Executives (AACE) has consulted with the ten NHS ambulance trusts in England to provide this response to the consultation on behalf of the sector.

With respect to the two options proposed for Integrated Care Systems (ICSs), there is widespread agreement from ambulance trusts that these should be given a statutory footing from 2022 as corporate NHS bodies with commissioning responsibilities. The main proviso for this would be that there should be no duplication of regulatory activity, accountability, or function with other remaining statutory bodies such as NHSEI or the Care Quality Commission (CQC). Arrangements for membership and governance will need to be defined and transparent, with clear principles and guidance that ensures all partners within an ICS are considered equally. ICS bodies will need to demonstrate their competence and effectiveness in commissioning the range of service provision, especially from providers such as ambulance services, that span more than one ICS.

AACE has endeavoured to reflect the common position of its members on how other elements of the consultation proposals may impact on or present opportunities for the ambulance role in delivering high quality patient care and integration of services.

ICSs should be able to make good use of the regional knowledge and experience of their ambulance service to support identification of best practice, learning and transformation in implementing the aims of the LTP to move care closer to home, and safely reduce avoidable conveyance to emergency departments (EDs). There are opportunities for using evidence-based pathways flexed to local need more widely across regions e.g. frailty pathways.

Ambulance services need to be strategic *and* local partners if they are to collaborate with optimal effect. In addition, they need to be considered alongside community providers to benefit from the risk share arrangements which will come into effect under ICSs.

Working locally at place level *and* as a regional provider is what ambulance trusts do now, across the country, but it is not without its challenges, and we would welcome clear guidance within the *Integrated Care* proposals on how this can be managed more realistically and effectively.

The integration of workforce planning across an ICS (and regions) is more important than ever, with many professions in short supply and capacity being outstripped by the requirements in each partner's workforce. The ICS should play a role in ensuring lack of clinical supply does not result in a local market economy and inflated costs for providers.

[1] NHS England » Integrated care systems

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The *Integrated Care* proposal for provider collaboration potentially offers greater opportunity for ambulance services to engage within and across ICSs, which would help all partners better understand variation in access to services and outcomes due to geography, race or socio-economic factors. Stronger emphasis on collaboration needs to require the embedding of tangible means (forums, processes, systems) to share best practice and harmonise clinical pathways within ICSs and across the wider regional footprint. This would encourage the adoption of the most clinically effective and efficient models and reduce unwarranted variation or postcode inequalities. Learning from the COVID-19 pandemic response, we know that there are opportunities to improve productivity, efficiency, and costs when certain aspects of service provision can be done collaboratively, at scale, across ICS footprints. The solution to many performance issues within systems can be better addressed through provider collaboration and partnership working than by focussing on individual providers in isolation; particularly so for the ambulance sector, where performance can be so significantly impacted by wider system issues.

Section 1.19 of the consultation paper is a crucial and welcome acknowledgment that there are services that need to be organised on a regional basis due to the size, geographic footprint, and nature of the service. We believe that ambulance services firmly fit into this category. By commissioning and planning ambulance services on a regional basis, and through collaborative working across systems, it will be possible for their populations to 'experience fair access to these services, based on need and not factors such as geography'. Given the importance of service resilience and equity of delivery, we would be keen to see regional coordination of ambulance service commissioning.

AACE would welcome a strategic commissioning approach which is wider than individual ICS systems. Our preferred model would involve the establishment of a regional[2] strategic commissioning board that includes representatives of each of the ICSs covered by the ambulance trust, plus the respective NHSEI region(s). To minimise bureaucracy and complexity, it is suggested that a single ICS would manage, chair and administer the board but decisions would be made by the full membership. This would ensure that the full scope and responsibilities of the ambulance service would be considered in a single commissioning forum.

This option would enable ambulance services to be designed and planned at the appropriate level. It would also ensure all ICSs have equal responsibility for ambulance commissioning, funding and decision making whilst maintaining alignment on a local level so that, where appropriate, services could be tailored to best meet the needs of local populations. This model would also encourage greater collaboration across ICSs within the region.

There is, however, a risk associated with regional commissioning of block contracts which are averaged out at scale but do not take adequate account of variabilities across a range of territories, locking services into unaffordable agreements which are difficult to negotiate. An alternative to this would be a blended approach where an ICS is empowered to work as a collaborative with another ICS, enabling consistency for some key services but allowing for some local variation. For example, where an ambulance service may wish to set up a different kind of collaborative with another healthcare provider for specific work relevant to "place".

[2] 'Regional' referring to the regional footprint covered by the ambulance trust

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Having a central funding pot that crosses service lines - rather than being held within organisational boundaries - would help reduce individual financial incentives and move towards shared benefits, create aligned incentives, productivity gains and efficiencies e.g. introduction of increased integrated urgent care and community services to reduce ED attendances and hospital non-elective admissions. Ambulance trust commissioning needs to ensure adequate funding for 999, PTS and 111 (where delivered by the ambulance trust) to deliver the core contract so this protection would be required, i.e. an integrated model and funding. A pooled budget as suggested here could potentially put this at risk if adequate controls were not in place.

Rebalancing the focus between NHS organisations and reducing competition will be a significant enabler to effective service redesign across NHS organisations. It will increase and accelerate patient pathway transformation, productivity and reduce inefficiencies caused by market competition across NHS and non-NHS. It is important that organisations must be able to demonstrate the ability to achieve high quality patient focused care whilst also delivering value for money for the taxpayer. NHSEI tools such as Model Hospital and Model Ambulance could be used to support this.

We conclude our feedback to this consultation with some key principles that our members request should be borne in mind as the proposals for Integrated Care are developed and taken forward.

AACE looks forward to continued engagement with NHSEI in contributing to these developments, to ensure the ambulance sector can play a full and effective part in improving safety, experience, and outcomes for patients.

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Part 2: NHS England and NHS Improvement Consultation

NHS England and NHS Improvement (NHSEI) have launched a consultation process inviting discussion about how Integrated Care Systems (ICSs) could be embedded in legislation or guidance.[3] This is with the aim of delivering against the NHS Long Term Plan (LTP) in supporting greater collaboration between partners in health and care systems.

From April 2021, all parts of the health and care system will be required to work together as ICSs, involving:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale;
- Developing strategic **commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

The consultation describes two options for giving ICSs a firmer footing in legislation from April 2022.

Integrated Care Systems - Options

1. A statutory committee model with an Accountable Officer that binds together current statutory organisations
2. A statutory corporate NHS body model that additionally brings clinical commissioning groups (CCG) statutory functions into the ICS

Feedback from ambulance trusts to NHSEI consultation questions:

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

There is widespread agreement from ambulance trusts to this in principle. For ICSs to have a statutory footing will help provide clarity in terms of the requirement of organisations to collaborate and utilise resources together, especially regarding allocations of funding, accountability, payment mechanisms and introducing system incentives based on outcomes, rather than interventions or activity. Without the statutory footing it is felt that there is a danger of ICSs not being accountable to the public and people they serve.

[3] NHS England » Integrated care systems

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Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

There is some doubt in respect of how well this will work in practice without consistent oversight from NHSEI and a clear governance framework. There is, however, greater potential for creating meaningful collaboration between partners with a focus on patient-centred care if statutory requirements are adhered to and implemented well.

The proviso would be that there should be no duplication in regulatory activity, accountability, or function, so for example, whilst CCGs will change, some of what the ICS would do is also currently undertaken by NHSEI. There also needs to be policy work done with the Care Quality Commission (CQC), who can only regulate at individual trust registration level - will the CQC now regulate ICSs too?

Q. Do you agree that other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

There needs to be some flexibility for this purpose, but ICSs will need to follow some level of guidance and design principles so that regional partners, such as ambulance services, are not having to comply differently for multiple governance systems. Their contribution and investment needs must be appropriately prioritised compared to other types of providers who are more local or are specifically aligned with the system. This would require consideration for regional contracts.

The ability to set and shape governance arrangements that suit a specific ICS area will support their ability to reflect population and place needs, alongside working with voluntary and third sector organisations that provide outstanding care for patients in their local areas. To exclude these, or not have flexibility in governance to include them, would potentially put at risk all of these gains that have developed over the years with local patient groups. Different aims, governance structures and objectives of Voluntary Care Services (VCS), Community Interest Companies (CIC) and other bodies could however add complexity to decision making.

Local Authorities (LAs) absolutely need to have a role here; they are also locally accountable to the people they serve. Some LAs have walked away from Sustainability and Transformation Partnerships, so should they be mandated to participate as partners in ICSs?

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Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSEI should be either transferred or delegated to ICS bodies?

There is broad agreement for this, although due consideration should be paid by NHSEI to those services where regional footprints or highly specialist delivery is best done at scale (multi-ICS), as these may be better remaining with NHSEI or moving to a regional commissioning model.

The principle should be that health and care services should be commissioned as close to the point of need as possible. Some NHSEI contracts are best managed nationally/regionally to ensure equity and there could be potential for ambiguity/confusion and misinterpretation if handed down to ICS level. ICS bodies will need to demonstrate they will be competent and effective in commissioning such services and those providers would need confidence in their ability to be so.

In the case of ambulance services, national intervention has been required to address failings within current local commissioning e.g. the Ambulance Improvement Programme, national NHS111/IUC review and the ongoing non-emergency patient transport review. There is little to suggest that similar national oversight will not be required going forward, unless commissioning arrangements better recognise the role and impact of ambulance services on the wider system.

AACE would welcome a strategic commissioning approach which is wider than individual ICS systems. Our preferred model would involve the establishment of a regional strategic commissioning board that includes representatives of each of the ICSs covered by the ambulance trust, plus the respective NHSEI region(s). To minimise bureaucracy and complexity, it is suggested that a single ICS would manage, chair and administer the board but decisions would be made by the full membership. This would ensure that the full scope and responsibilities of the ambulance service would be considered in a single commissioning forum.

This option would enable ambulance services to be designed and planned at the appropriate level. It would also ensure all ICSs have equal responsibility for ambulance commissioning, funding and decision making whilst maintaining alignment on a local level so that, where appropriate, services could be tailored to best meet the needs of local populations. This model would also encourage greater collaboration across ICS ‘s within the Region.

There is, however, a risk associated with regional commissioning of block contracts which are averaged out at scale but do not take adequate account of variabilities across a range of territories, locking services into unaffordable agreements which are difficult to negotiate. An alternative to this would be a blended approach where an ICS is empowered to work as a collaborative with another ICS, enabling consistency for some key services but allowing for some local variation. For example, where an ambulance service may wish to set up a different kind of collaborative with another healthcare provider for specific work relevant to "place".

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Part 3: Further views from the NHS ambulance sector

AACE has collated feedback on some of the specific elements of the *Integrated Care* consultation document to reflect how these may impact on, or present opportunities for, the ambulance role in delivering high quality patient care and integration of services.

Devolution of functions and resources (para 1.12)

Ambulance services agree that ICSs need to be able to prioritise finances and resources to meet the needs of their populations, indeed it is one of the fundamentals behind their creation. However, an appropriate level of governance and scrutiny is necessary to ensure that they discharge their duties appropriately, and these mechanisms have yet to be defined.

Engagement on the **development of control mechanisms** is necessary to ensure that they are appropriate and agreeable to all partners and providers engaged in each ICS footprint. There also needs to be a potential route for re-evaluation should decisions on funding, for example, not adequately meet the needs of a provider as demand patterns and care pathways change. It is imperative that funding moves within a system appropriately and on the basis of a clear understanding of rationale.

ICSs should be able to make good use of the regional knowledge and experience of their ambulance service to support identification of best practice, learning and transformation in implementing the aims of the LTP to **move care closer to home and safely reduce avoidable conveyance** to emergency departments (EDs). There are opportunities for using evidence-based pathways flexed to local need across regions e.g. frailty pathways.

The priorities listed for each system should be considered on both an operational and fully strategic level to ensure that plans and funding streams cater for current as well as future need and development. Ambulance services undertake annual demand and capacity forecasting based on sophisticated modelling of need and planning assumptions across their region. This is a practice that ICSs could benefit from doing collectively on a wider scale across service provision, which would facilitate planning and demonstrate impact of service reconfigurations on patient access to services and provider capacity.

ICSs will need to ensure that they are addressing priorities for the populations they serve, but if arrangements become such that they are a lead ICS hosting the ambulance service, they need also to be able to reflect the priorities of the other relevant ICSs and compromise accordingly. Funding allocation needs to account for requirements that fall outside the host ICS boundary e.g. ambulance capital programmes. With the current commissioning setup along these lines, it has proved challenging to secure investment agreement from multiple CCGs even with a lead ambulance CCG. The ambulance service needs to be appropriately prioritised alongside the providers who are more local or specifically aligned with the system.

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Ambulance trusts invariably welcome the continued focus on **reducing inequalities**, as per the LTP, however a major challenge in this can be that the devolution of resources is at place and Primary Care Network (PCN) level, meaning that the ambulance trust must flex to support individual plans, not only at a place base, but also at a neighbourhood level. There is a risk in tackling **inequalities** solely at this level of an adverse impact on resourcing emergency response to patient across an ICS. However, if inequalities also incorporated ambulance response times, then it could improve services for patients in rural areas, for example.

Improvement and transformation of resources from a commissioning perspective is currently within the mandate of CCGs and PCNs and GP Provider Organisations whose main remit is localities within ICS footprints. To enable ambulance trusts to have more than a "seat" at the table requires strategic commissioners to be thinking rather differently from how they currently operate. Many ICSs are split into children's, adults', planned and unplanned care. Ambulance services have the ability to operate in a more community-led and localised way, providing whole life services and working to prevent emergency admissions. They are often on the receiving end of planned pathways (end of life being a good example).

Ambulance services need to be strategic and local partners if they are to collaborate with optimal effect. In addition, they need to be considered alongside community providers to benefit from the risk share arrangements which will come into effect under ICSs. Under current arrangements it can be challenging to engage places to work in partnership on opportunities. Ambulance representation in place decision making forums and ICS level leadership offer a potential solution to this. There is a risk though that some systems may seek to fragment current regional ambulance and NHS111 provision which in turn would risk diluting current strengths in economies of scale, resilience, and governance.

The opportunity for **collective accountability** between partners is promising, given the interdependencies between providers, and where challenges such as handover delays and ineffective / unavailable alternative pathways are causing additional pressure on the whole urgent and emergency care (UEC) system. But, as voiced before, the mechanisms for how this would work have yet to be thought through.

The integration of **workforce planning** across an ICS (and regions) is more important than ever, with many professions in short supply and capacity being outstripped by the requirements in each partner's workforce. The ICS should play a role in ensuring lack of clinical supply does not result in a local market economy and inflated costs for providers.

Collaborative workforce planning would provide an opportunity to embed new roles aligned to patient pathways, rotational roles and more flexible career frameworks that allow consistent traversing across all partner providers. ICS level planning will also facilitate sharing of good practice and expertise in workforce planning, engagement with higher and further education etc. Given the specialist nature of some ambulance service roles as well as the disparity between the numbers of paramedics available and the number required within regional systems, there

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may be a stronger need to maintain national and regional workforce planning through Health Education England (HEE) and sector collaboration. It is disappointing that the clinical role of paramedics is not explicit in the guidance.

The PCN Additional Roles Reimbursement Scheme (ARRS) scheme is a prime example of how ambulance workforce skill sets can be utilised within a local setting. The resourcing of this must, however, be more realistic and driven with the correct incentives to support ambulance trusts in offering workable, rotational model proposals to PCNs that create attractive roles for paramedics and retain their skills across systems.

The devolution of **workforce planning and educational commissioning** could potentially have a detrimental effect on services, such as ambulance, that operate on a regional footprint. Current arrangements with a single commissioning lead have led to ambulance services missing out on access to development monies, for example to support the development of advanced practitioners. These are key roles needed to increase provision of 'hear & treat' and 'see & treat' care at scale, as well as take responsibility for vital clinical mentoring and supervision within the ambulance sector, all of which reduces hospital attendance and admissions. There needs to be a clear requirement for ICSs to support the ambulance workforce and to consider their supply and development needs in the round. Having localised developments, priorities and approaches could leave ambulance trusts with differing offers or educational opportunities in different areas depending on the priorities of each ICS. This has happened in places, with individual CCGs commissioning local Emergency Care Practitioner and Specialist Community Paramedic roles. This has led to a fragmented approach to career development, clinical and operational leadership and complexity due to the number of models in operation. This could place a financial burden on ambulance trusts in trying to replicate or standardise provision across the regional footprint. Overall, there are risks of fragmentation for ambulance services with differing arrangements for a range of workforce issues across several ICSs which could fundamentally impact on overall paramedic supply, not just for the ambulance service but for wider urgent and primary care systems around them.

Digital developments are necessary to support an effective, well equipped workforce and the public and patients expect more seamlessly joined up systems, especially around integrated data to support treatment pathways. **Digital solutions and data management** drive system working and improved outcomes for patients, including greater access to clinical records for patients 'in the field' as well as use of advanced analytics to plan healthcare provision between partners.

Whilst the proposals rightly identify the importance of ICS level digital strategies it will be important to work at a regional level as well to minimise duplication and maximise economy of scale and pace of delivery. In the digital space it is necessary for multiple ICSs to work together with their ambulance service to deliver – for example recent work on accessing local health and care record exemplars (LHCREs). Having the ambulance trust recognised as a system leader for digital solutions can be helpful in delivering interoperable solutions. The regional system

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versus local challenge is that some ICSs will break away from regional digital collaborations, so there is a high likelihood of the ambulance trust having to engage in multiple new information management systems and digital developments within their region.

Having collective accountability through an ICS, or preferably at regional level, for **emergency preparedness, resilience and response** offers an opportunity to improve cooperation across all providers in developing major incident plans and for when a coordinated response is needed. Current local arrangements with A&E Delivery Boards can lack clear accountability and lead to duplication. During the COVID-19 pandemic response, having coordination at both national and regional levels for ambulance services has been essential. In addition, their regional oversight for coordinating PTS service provision worked well, as has the national COVID Response Service (CRS) for NHS111 COVID calls (hosted by South Central Ambulance Service). Both of these have clearly demonstrated the benefits inherent in partner providers coming together effectively.

Working at place (paras 1.15 and 2.31) & place-based partnerships (para 2.17)

We agree with the **ambitions for local populations at place** (although place needs a clear definition) and that is the right level to ensure that the population has the services they need and deserve, but there must be an acceptance at place level that there is a need to contribute to some system or region based services where those services can be best delivered at scale.

Working locally at place level *and* as a regional provider is what ambulance trusts do now, across the country, but it is not without its challenges, and we would welcome clear guidance, with principles of collaboration/partnership to be adopted within the integrated care proposals so this can be managed more realistically and effectively.

Currently, alongside their 999 contract, ambulance services respond within local schemes delivering to locally identified needs. These range from provision of early intervention vehicles and multi-disciplinary teams (MDTs), falls response schemes and particular care pathways (e.g. stroke, diabetes or frailty) that facilitate direct referrals away from EDs. There are also opportunities to join up with mental health, social work and other emergency services. Many of these needs do not differ greatly from place to place, but the solutions put in locally often do, or in some areas are simply not there. There are potential benefits if best practice and learning from local care pathways could be implemented on a wider scale across ICSs within a region to make them more consistent, recognised and accepted by providers and patients alike and put them onto a more sustainable and equal footing.

Through development of integrated care, particularly for UEC, and shared patient records, ambulance services can make a significant contribution to the navigation and utilisation of **alternative pathways and preventative services**. Investment in technology will be key, so a regional service can connect patients to locally provided services to best meet their needs.

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Within any proposed future structures there is an opportunity to recognise the role of ambulance services across the prevention spectrum. Ambulance clinicians can have a significant role in primary and secondary prevention using their millions of interactions with patients each year to deliver **ill health prevention and health promotion messages** – Making Every Contact Count (MECC). The unique role of the ambulance sector means they are perfectly placed to deliver effective primary prevention, by identifying risk factors and facilitating connections to supportive services within systems. The longer-term impacts of the current COVID-19 pandemic on the social determinants of health are beginning to emerge, increasing the need for a collective approach to tackling inequalities, which the ambulance sector is well placed to contribute to. There is also a clear opportunity to support follow-up activity such as recuperation and recovery services for the elderly, where paramedics may be working within the primary care setting. Not only this but ambulance sector staff have a vital role in connecting patients into other parts of the health and social care system so that they receive the right care moving forwards.

Ambulance services also make a significant contribution to the health and wellbeing of local populations and communities in their role as anchor institutions and their ability to impact on **social and economic development** through procurement, recruitment, training, and volunteering opportunities as well as supporting environmental sustainability across the region.

This public health remit is, however, rarely commissioned and thus is inadequately resourced and the opportunity to realise the impact that the ambulance sector can have is missed.

Planning a delivery model at place level (to whatever extent) cannot be done without understanding the impact on regional provider performance management metrics unless these are to be further localised or altered (which in itself is not practicable). The disconnect between local place and ICS level delivery and performance requirements of a regional provider are currently a significant juxtaposition to manage.

From the ambulance service perspective, there are a number of aspects that should be done at a 'once for the region' level including major incident response and key IT infrastructure systems e.g. triage platform and Computer Aided Dispatch (CAD) systems.

We welcome specific references to the ambulance service as a partner in place and *Integrated Care* refers to the need for **"full involvement of all partners"**. It would be helpful though to understand what "full involvement" constitutes. Membership of place-based partnerships is potentially a tricky issue due to a lack of definition of relationships between the provider chain at local level. Given their wide geographic spread, the ambulance voice within each place is currently diluted relative to larger place-based providers, which risks diminishing the ambulance involvement and impact on this agenda.

Additional membership of each place partnership could or should also include public health, education, community, and social care alignment.

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Alignment to local authority areas will increase the number of places to engage with, so there will be a need to increase resourcing for ambulance trusts to allow operational management structuring and board level leadership development to support engagement or, there will need to be agreement on where engagement occurs within existing, limited capacity.

With the introduction of PCNs, the ARRS offers an opportunity for ambulance services to work with them to support this but given the hundreds of PCNs within an ambulance region, this presents the challenge of effective resourcing at a time when staff retention and recruitment is a real issue for the ambulance sector. Many PCNs are yet to fully develop their requirements for the First Contact Community Paramedic (FCCP) role and what it will bring to their care delivery. As discussed earlier, the totality of the workforce planning challenge needs to be considered at an ICS and regional level prior to PCNs employing FCCPs, or ambulance services supporting rotation of their own workforce into FCCP roles in primary care. It is also essential that the impact of a shift in the ambulance response workforce to primary care is considered from an ambulance KPI perspective, and not just at an ICS level.

Place based partnerships are essential to support local pathways but prioritisation and strategic leadership needs to be at an ICS and regional level. ICSs also need to recognise the potential benefits of some place-based solutions being established at scale across a region. In addition, it is important to recognise that a place may not always be physical in nature and the ambulance sector in future will be expected to direct patients to the most appropriate place. Effective clinical partnership working is critical to making all of this work.

Provider collaboration (paras 1.18 – 1.21 and 2.9)

All ambulance trusts would welcome a greater emphasis on provider collaborative working, and a move away from the commissioner-provider relationship. We see many opportunities to **improve both horizontal and vertical integration of care**. Ambulance trusts are a vital part of the healthcare system that can be developed to offer a much greater range of services and care, working in collaboratives as equal partners for the benefit of patients.

Ambulance services have been established as regional providers since 2006, covering large populations (circa 3 - 9m) usually with a mix of urban, rural, and sometimes coastal features in each region, and a range of demographic patterns. As such, they can exploit efficiencies of scale, optimise use of their resources, reduce unwarranted variation, and operate with relatively small leadership/executive teams. Being a regional provider can, however, have its disadvantages with the current arrangements for commissioning, but there are many benefits that could be better realised if commissioning arrangements and collaborative working allowed. Learning from the COVID-19 pandemic response, we know that there are opportunities to improve productivity, efficiency, and costs when certain aspects of service provision can be done collaboratively, at scale, across ICS footprints.

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Primarily, ambulance trusts have **good oversight and knowledge of health and care demand and provision** across their patches, which can contribute significantly to population health management and planning of services. Their dynamic day-to-day business intelligence could also assist ICSs in capacity management and provide early warning for when the system is 'heating up'.

Being the **entry point into healthcare**, particularly where NHS111 and booking services are also provided, ambulance services have expertise in triage processes, coordination of a range of clinical responses and navigation of care provision – all of which can ensure each patient gets the right care, from the right clinician, specialist or team, in the most appropriate setting, when the appropriate care provision is available. True provider collaboratives offer the potential to do this on a wider scale, more efficiently and effectively than is currently the case, and this extends not just to the delivery of service but also its design and development.

The *Integrated Care* proposal for provider collaboration potentially offers greater opportunity for ambulance services to engage within and across ICSs, which would help all partners better understand variation in access to services and outcomes due to geography, race or socio-economic factors. Stronger emphasis on collaboration needs to require the embedding of tangible means (forums, processes, systems) to share best practice and harmonise clinical pathways within ICSs *and* across the wider regional footprint[4]. This would encourage the adoption of the most clinically effective and efficient models and reduce unwarranted variation or postcode inequalities. The solution to many performance issues within systems can be better addressed through provider collaboration and partnership-working than by focussing on individual providers in isolation; particularly so for the ambulance sector, where performance can be so significantly impacted by wider system issues.

It needs to be acknowledged that the current focus on CCGs and place structures can sometimes hinder wider collaboration (due to the 'not invented here' approach). Stronger ICS governing structures and powers could support facilitation of wider clinical networks and participation to support adoption and spread of innovation and best practice.

The *Integrated Care* proposals for provider collaboration potentially provide greater opportunity for ambulance services to engage within and across ICSs, which would help all partners better understand variation in access to services and outcomes due to geography, race or socio-economic factors. Stronger emphasis on collaboration needs to require the embedding of tangible means (forums, processes, systems) to **share best practice and harmonise clinical pathways within ICSs *and* across the wider regional footprint.** This would encourage the adoption of the most clinically effective and efficient models and reduce unwarranted variation or postcode inequalities. The solution to many performance issues within systems can be better addressed through provider collaboration and partnership working than by focussing on individual providers in isolation. Particularly so for the ambulance sector, where performance can be so significantly impacted by wider system issues.

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[4] For example, NE & Yorkshire Regional NHSE/I have recently set up a regional Integrated UEC Board involving commissioners, ED and ambulance clinicians, ambulance trusts and regulators which presents a good model going forward.

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Any future framework needs to provide a **single regional operating model** but with the ability to engage in delivering local solutions.

AACE continues to propose a **model for integrated urgent and emergency care** to join up access via 999 or 111 or Out-of-Hours numbers with a single, multi-disciplinary Clinical Assessment Service 9CAS) at regional level, and so provide an appropriate immediate response or appointment booking service at local level, or self-care advice – whichever is the most appropriate care for each patient. This model describes a provider collaborative that exploits economies of scale, optimising use of scarce resources, especially workforce and the range of disciplines needed within a CAS (see Appendix).

This kind of provider collaboration, to provide **a 'complete offer' to patients**, is becoming increasingly important in addressing long term conditions (LTCs), mental health (MH), end of life care, falls and frailty needs, for example MDTs responding to complex frailty call outs. Connectivity of services and interoperable digital systems are currently key challenges for ambulance services in meeting the needs of patients, for example, enabling teams to directly interact with in-taking specialties in hospitals, and/or making direct referrals to community teams to take care to the patient where possible and viable.

Section 1.19 of the consultation paper is a crucial and welcome acknowledgment that there are services that need to be organised on a regional basis due to the size, geographic footprint, and nature of the service. We believe that ambulance services firmly fit into this category. By commissioning and planning ambulance services on a regional basis, and through collaborative working across systems, it will be possible for their populations to 'experience fair access to these services, based on need and not factors such as geography'. Given the importance of service resilience and equity of delivery, we would be keen to see **regional coordination of ambulance service commissioning**.

The ambulance service is often a partner in system development, but the level of investment required is not always recognised because of the relative size of an ambulance trust to an acute. Funding within systems needs to be appropriately allocated to ensure that services, pathways, and initiatives can be developed at the right pace and at the right scale.

PCNs & population health management (para 2.18)

Given the wealth of data and business intelligence information collated through 999 and NHS111, ambulance services could play a far greater role in working with systems and places to understand and identify high risk groups within populations. They could also make a greater contribution, working in partnership with other agencies, in ensuring patients receive appropriate support. Working collaboratively and joining up care is also about enabling the population to make choices and not always see ambulance services as the backstop option (especially out-of-hours) for a non-urgent or emergency matter.

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PCNs and place represent the right levels to address local needs, but it will be important to establish strategies for digital technology and data (and clear accountabilities) that support delivery of integrated care beyond individual place boundaries.

Ambulance services have a responsibility to support integrated local care delivery, but this needs to be balanced against costs and challenges and diseconomies of bespoke services for each place or neighbourhood. As suggested earlier, there needs to be greater learning and sharing of good, evidence-based practice across ICSs to consolidate or have more consistent approaches to specific patient or population needs. This would help avoid duplication of effort, re-inventing the wheel and unintended consequences of introducing a local pathway that impacts negatively on the wider system or elsewhere in the region. Equally, ICSs need to ensure there are no conflicting priorities when supporting local needs. Workforce and skill mix suffer greatly when not aligned or prioritised appropriately.

As previously stated, the function of FCCPs in PCNs needs to be clarified alongside the effective system and regional leadership of workforce and performance planning. PCNs currently need support to develop their understanding of the service they will be expected to offer. Our work with rotational paramedic schemes suggests that the requirements and expectations of PCNs differ greatly. It is therefore important that PCNs are supported to develop collaborative partnerships and recognise that resources, for the moment, will need to be shared adequately whilst the number of qualified practitioners grows.

Financial framework (para 2.40)

The suggested financial framework aligns well to other elements of the proposed approach and some ICSs have made a positive start along these lines. Assurance that this model would support ambulance service priorities and transformation beyond any host ICS boundary would be welcome if this were to be the adopted national arrangement.

For ambulance services, that currently contract with multiple CCGs for ‘elements of funding’ and often miss out on transformation funds, the idea of having **fewer commissioning pots** (one per ICS) to draw from is very welcome. What needs further clarity, however, is the mechanism that supports the allocation of each central pot and how procurement activities could change. In the second ICS option, commissioning is effectively handled by a lead ICS commissioner on a greater scale to that currently operated by groups of CCGs. How that changes procurement is unclear but could be open to varied interpretation by different ICSs. This needs robust governance as the lead or host commissioner framework has downsides especially for non-core services which will have different ‘customers’, such as at place level. There remains the risk that ICS’s focus may be directed towards acute, community, mental health and primary care provision so ability for ambulance to access national transformation funds may continue to be constrained.

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In addition, many ambulance trust contracts will span ICSs hence the rules of engagement in these examples need careful clarification and definition. As a regional provider, the **benefits could be diluted for the ambulance service** if trying to agree service redesign and payment mechanisms across multiple ICSs. It is imperative that service redesign partners must have budgetary authority and autonomy. If not, this could stifle progress, as different ICSs may have different people and place needs and competing priorities.

Having **a central funding pot that crosses service lines** - rather than being held within organisational boundaries - would help reduce individual financial incentives and move towards shared benefits, create aligned incentives, productivity gains and efficiencies e.g. introduction of increased integrated urgent care and community services to reduce ED attendances and hospital non-elective admissions. It would also help remove current perverse incentives in the system and better align spend in several areas – e.g. separation of primary care budgets from acute care has resulted in disinvestment in some areas of primary care, which has simply resulted in driving activity, cost and spend in acute care. Ambulance trust commissioning needs to ensure adequate funding for 999, PTS and 111 to deliver the core contract, so this protection would be required, i.e. an integrated model and funding. A pooled budget as suggested here could potentially put this at risk if adequate controls were not in place.

Reform of the financial framework, alongside tariff reform, is not enough to shift the dial on ambulance commissioning. A policy shift is also required to increase emphasis on delivery of ambulance response programme (ARP) standards – including a greater understanding of the interdependencies of performance between EDs and ambulance services. There are questions that would need addressing in relation to the potential negative impact to the 999-contract budget within the single pot approach and also what opportunities it may open up for bidding/collaborating around nationally held transformation monies. Regional commissioning of core ambulance services, and national commissioning of specialist national capability resources e.g. Hazardous Area Response Teams (HART) could provide greater assurance of sustainability and performance in these respects.

Current regional lead commissioner arrangements together with national oversight provide some safeguards that commissioning supports delivery of national operational standards for 999 and 111. It is not clear how the proposed ICS commissioning approach would maintain this focus.

Without adequate legislation / policy guidance the current financial framework also risks diluting focus on provider efficiency whether NHS, CIC or VCS.

Another concern raised by our members is that there is **no standard national payment policy** for ambulance services. Items like the application of standard inflation do not recognise the differential ambulance sector impact, and so must be negotiated by each trust. Financial frameworks at a system level risks this being amplified.

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A more **structured approach to tariff/contract value setting** is needed across the ambulance commissioners. National tariff rules are weak and allow investment conversations to be driven by historic cost/affordability issues at the cost of performance or patient risk issues. The current proposals to allow increased flexibility locally further lock in historical funding issues, rather than ensuring increases in resources are provided to deliver ARP standards, which are currently aspirational given under funding across the sector.

Introduction of an **ambulance investment standard** – such as the Mental Health Parity of Esteem investment standard. Ambulance services are undervalued generally and too small to ensure their voice is heard individually in local systems. A mandated investment standard would support at least maintaining investment levels in the service at the same rate as the wider system.

Single oversight framework (para 2.58)

The enhanced position of systems in oversight is broadly welcome although the proposal does not identify specific performance and quality measures.

It is not clear within the guidance how oversight will apply to organisations that span more than one ICS boundary, where targets are trust-level, not ICS level. Having one body with **oversight on a regional basis**, which could address concerns of inequality across systems, is also needed. The links between provider and system accountability would need to be fully understood to ensure alignment.

For ambulance services, participating meaningfully in a single oversight framework at a local ICS level would only be feasible if funding for ambulance services was made available to deliver ARP performance at a local ICS level.

There are areas of performance, however, where a single oversight framework at ICS level would deliver improvement, such as the direct correlation between handover delays and ambulance resource availability, patient safety, and response performance. There is, however, always an inter-ICS impact of handover delays as resources are dynamically utilised across the region to mitigate extended response times, so here a regional oversight framework may be required too.

The risk remains with a single oversight framework of the potential to default focus on acute trust performance. How will this help other partners - particularly primary care and community-based services, who are major players in a system but are barely 'measured' in comparison to hospitals and ambulance trusts?

Clarity is required on the **links with the CQC registration** and regulation at provider level. A failing system could be treated in the same way as a failing provider. The CQC has yet to

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set its future inspection criteria but ICSs will require scrutiny and performance management should the need arise.

This point should not allow the performance of failing providers to be hidden within the acceptable performance of a larger system. The health service is effectively experienced at a patient level which is where good governance needs to focus with a clear line of accountability throughout the health service to ensure that improvements can be identified wherever they are effectively needed.

Abolition of competition authorities (para 2.61)

Ambulance services welcome proposals to revoke S75 of the Health and Social Care Act and the removal of NHS services from Public Contract Regulations.

Rebalancing the focus between NHS organisations and reducing competition will be a significant enabler to effective service redesign across NHS organisations. It will increase and accelerate patient pathway transformation, productivity and reduce inefficiencies caused by market competition across NHS and non-NHS.

The current system of **frequent competitive tendering is inefficient** and ties up a significant amount of leadership time and resource that could be far better utilised on service improvement and delivery. Long term transformation, investment in services and high-quality outcomes for patients can be driven through service stability. In a future operating environment where ICSs are genuine partnerships between healthcare organisations, stability will be critical in ensuring meaningful relationships can be formed, along with trust and co-developed service models. The not-for-profit nature of the ICS-first principles means a greater reliance on partners working within the ICS cost-envelope and designing pathways and service delivery that are cost effective.

Commissioning of 111/IUC services and non-emergency PTS has not always been via a sufficiently well-informed procurement process and this has on occasion led to contract failures and suboptimal outcomes for patients and service users. Several ambulance trusts have had to step in when other private sector providers for 111 and PTS have exited the market. The proposals could help avoid these situations if replaced by a more strategic commissioning approach. One key lesson from the COVID-19 pandemic response has been how running the national CRS for NHS 111 and also PTS (with regional coordination by each ambulance trust) alongside 999 has significantly supported resilience and stability.

Long term call centre service (for 999 / 111) and healthcare transportation needs to be commissioned directly to ambulance trusts for **10 years minimum contracts** to allow for appropriate capital investment in sustainable services. Other service providers would still be engaged as collaborative partners in supporting the ambulance trusts which would effectively commission the services they need. The significant time invested in long drawn-out procurement exercise could then be spent on improving services.

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Where trusts can generate commercial income streams through leveraging key competencies, they should continue to be allowed to do so providing they do not undermine delivery of core NHS services.

It is important that organisations must be able to demonstrate the ability to achieve high quality patient focused care whilst also delivering value for money for the taxpayer. NHSEI tools such as Model Hospital and Model Ambulance could be used to support this.

Strategic commissioning (paras 2.63 and 2.66)

The ambulance sector supports the move to a single system-wide approach to strategic commissioning and the proposal offers an opportunity to strengthen existing, less formal arrangements for ambulance commissioning at a system and regional level.

Whilst we support the principle of subsidiarity and increasing the engagement of ambulance services in local place forums, we strongly believe delivery of core ambulance services (999, 111 and PTS) is **best organised at a regional level**. This does not preclude strong partnerships with ICSs and places to agree strategic priorities and ensure service delivery is fully integrated with local pathways of care. Provider collaboratives for ambulance services needs to span place-based partnerships whilst supporting ambulance sector national and pan regional collaboration to ensure resilience and economies of scale.

From a regional provider's perspective, it is important that commissioning should be simplified, and bureaucracy reduced. Having fewer commissioners and organisational boundaries should facilitate effective commissioning decision-making. Historically, decision-making across multiple commissioning organisations, across 30+ CCGs, without clear delegated authority has made service change more difficult and less efficient. There is a risk that community/place-based approaches do not consider or engage with organisations delivered at a larger regional scale.

AACE would welcome a strategic commissioning approach which is wider than individual ICS systems. We believe that, particularly for our most critically ill and injured patients, we must provide a consistently excellent level of service delivery. Often ambulance crews end up responding to 'category 1' incidents outside of their area, a more fragmented model would either risk the delayed response to these patients or increase the administrative or bureaucratic burden of maintaining it due to individual ICSs seeking to recoup costs for 'cross-border' service delivery .

The consultation document states that systems should agree whether individual functions are best delivered at system or place. For core ambulance services to be delivered at regional level there seem to be two options that would improve commissioning arrangements.

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The first would be to have a **lead or host commissioning ICS** that provides the strategic level oversight between the ambulance service and all the respective ICSs in that region, meaning negotiation with one decision making body for a regional contract that covers all core services – 999, 111, PTS. These services should be commissioned appropriately, with sufficient funding in place to meet predicted demand profiles and performance standards. Associated policies should be developed to support the prominence of ARP within strategic commissioning frameworks to avoid priorities being captured by larger, more prominent voices within health systems.

A second, preferred, model would involve the establishment of a **strategic commissioning board**, that follows Principle Two when considering 'specialised services' in para 2.72 of the *Integrated Care*[5] proposal. For ambulance services that span multiple ICSs (which is 9 out of 10 ambulance trusts) this could provide even greater benefits for patients.

A strategic commissioning board could include representatives of each of the ICSs covered by the ambulance trust, plus the respective NHSEI region(s). To **minimise bureaucracy and complexity**, it is suggested that a single ICS would manage, chair and administer the board but decisions would be made by the full membership. This would ensure that the full scope and responsibilities of the ambulance service would be considered in a single commissioning forum.

This option would enable ambulance services to be designed and planned at the appropriate level. It would also ensure all **ICSs have equal responsibility for ambulance commissioning, funding and decision making** whilst maintaining alignment on a local level so that, where appropriate, services could be tailored to best meet the needs of local populations.

There is, however, a **risk associated with regional commissioning of block contracts** which are averaged out at scale but do not take adequate account of variabilities across a range of territories, locking services into unaffordable agreements which are difficult to negotiate. An alternative to this would be a blended approach where an ICS is empowered to work as a collaborative with another ICS, enabling consistency for some key services but allowing for some local variation. For example, where an ambulance service may wish to set up a different kind of collaborative with another healthcare provider for specific work relevant to "place".

Any future commissioning body needs to include an appropriate level of understanding and experience of health transport and pre- or out-of-hospital clinical care delivery within the NHS. Furthermore, the commissioning model would need to create a focus for sharing best practice and areas for improvement which may span ICSs in the interest of patients.

In addition to a move to strategic commissioning of ambulance services, there is an urgent need to move to a **longer contract period** with agreements around blended payments. The current annual contract does not allow strategic decisions to be made and prevents effective workforce planning and hinders sustainability.

[5] "Principle Two: Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national"

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Also significant is the change in model, the proposed move away from payment by results (PbR) to permeations of blocks, and the risk that poses to a service that has only experienced significant growth in activity year after year.

We believe that there are a wide range of opportunities to benefit from consolidating activity utilising the logistics and coordination expertise of ambulance providers for ICSs and to ensure that transportation / pre-hospital care received appropriate investment.

Specialised services (paras 2.71 and 2.72)

The *Integrated Care* proposals refer to the potential for further aligning the design and provision of specialised services with linked care pathways, where it supports patient care, while maintaining consistent national standards and access policies.

The document goes on to describe three underpinning principles for development of specialised services, all of which could be applied to the range of services provided by ambulance trusts:

PRINCIPLE ONE:
All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.

This could apply in relation to the Integrated Urgent Care specification and the regional model of access to integrated urgent and emergency care put forward by AACE. It would also be appropriate for the commissioning of national capabilities, which are subject to a national service specification, such as the national CRS, hosted by South Central Ambulance Service, and other national capabilities such as HART and other emergency preparedness, resilience and response (EPRR) elements.

PRINCIPLE TWO:
Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national.

As discussed in the previous section – this presents an opportunity to establish a strategic commissioning board representing multiple ICSs to commission core ambulance services in their region.

PRINCIPLE THREE:
Clinical networks and provider collaborations will drive quality improvement, service change and transformation across specialised services and non-specialised services.

Ambulance services also need a voice when it comes to clinical networks and commissioning decisions, for example, around the further developments of regional and local pathways and configuration of services, eg stroke, cardiac, vascular etc.

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Key principles requested by ambulance trusts

i. Keep arrangements for integrating care simple, consistent, transparent, and open.

ii. Consistency, longevity, equity for patients and clarity, well ahead of the financial planning rounds.

iii. Ambulance trusts to provide regional leadership and coordination of access to urgent and emergency care through provision of an effective and efficient 24/7 first point of contact which coordinates, multi-disciplinary response to unplanned, out of hospital care, including urgent home visits.

iv. Ambulance trusts to be recognised as a key driver of collaboration and a model created where their involvement is mandatory not based on their ability to assert themselves with varying degrees of success.

v. Ambulance trusts to be considered as fully fledged members of ICSs, mandated as ICS partners at board level, and less of an afterthought regarding delivery of place-based, community and preventative services.

vi. Ambulance trusts embedded in local place partnership decision making structures at an ICS and place level e.g. UEC Boards and Alliance Partnerships.

vii. A regional based commissioning arrangement with scope for local additions but the core ambulance services funded regionally through a strategic commissioning board.

viii. Maintain some NHSEI regional oversight of ambulance commissioning, capital and transformation funding, via the strategic commissioning board.

ix. Move away from a short-term, activity-based contract to a 'guaranteed' income arrangement so we can ensure capacity is funded.

x. Some sort of activity uplift each year recognising when step changes are needed.

xi. Ceasing of penalty arrangements and instead, the introduction of sensible incentives e.g. for reducing conveyances.

xii. Preferred payment model: a blended model of fixed payments for core service delivery plus a variable activity related payment.

xiii. Contract pricing / trust income to reflect actual costs of running the service and meeting constitutional standards.

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xiv. **Block contract with tolerances and flexible provider collaboratives where this benefits health outcomes.**

xv. **A minimum tariff for 111 services as workforce shortages make it unsustainable to deliver within current funding.**

xvi. **A greater emphasis on ARP standards with commissioners to drive a greater need for investment in the service. Currently commissioners under value these standards.**

xvii. **A more structured approach to tariff/contract value setting across ambulance commissioning.**

xviii. **Introduction of an ambulance investment standard – such as the *Mental Health Parity of Esteem* investment standard.**

xix. **A payment model that is transparent and developed in partnership to ensure that trusts are not losing money providing services but funded appropriately with a reasonable financial challenge to offer value for money to taxpayers.**

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APPENDIX: The ambulance service offer: integrated urgent & emergency care

The Association of Ambulance Chief Executives (AACE) published a commissioning blueprint calling for greater integration of 999 and 111 call handling, clinical assessment and triage, and ambulance service provision in December 2019. The part played by the UK NHS ambulance sector during the COVID-19 pandemic further demonstrates its potential contribution, in terms of co-ordination, navigation and provision, to the collective delivery of integrated urgent and emergency care services alongside other providers and system partners.

NHS ambulance trusts in England operate on a regional footprint. 999 ambulance services are currently commissioned by local Clinical Commissioning Groups (CCGs), which ranges from seven to 32 for any one trust. These function across multiple sustainability and transformation partnership / integrated care system (STP / ICS) areas – with ambulance service contracts usually negotiated through a lead or co-ordinating commissioner. Currently 111 / integrated urgent care (IUC) contracts are commercially tendered and commissioned at an STP / ICS level.

An integrated regional approach to the commissioning of 999 and 111 services has the potential to bring about significant economies of scale and quality improvements across service provision, particularly in relation to call answering, clinical assessment and triage to:

- **Give patients better, faster and more appropriately delivered access to care closer to home;**
- **Help reduce ambulance dispatch, avoidable conveyance and pressure on A&E departments across the country;**
- **Result in greater synergies with wider STP / ICS partners in the primary care, acute, mental health and community sectors, transforming the integrated care system landscape;**
- **Facilitate the realisation of the aspirations for urgent and emergency care outlined in the Long-Term Plan (LTP);**
- **Enable the efficient pooling of 999 and 111 call handling and clinical advisor capacity in order to more flexibly meet demand;**
- **Enable trust boards - in line with their trust and enabling strategies and STP / ICS strategies - to enact longer term strategic priorities to expedite integration, reduce unwarranted variation and achieve productivity and efficiencies in line with Lord Carter recommendations;**
- **Provide resilience and interoperability of systems, workforce and services to deal with major incidents as demonstrated thought the recent COVID-19 pandemic.**

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NHS ambulance trusts in England operate on a regional footprint. 999 ambulance services are currently commissioned by local Clinical Commissioning Groups (CCGs), which ranges from seven to 32 for any one trust. These function across multiple sustainability and transformation The AACE would welcome a revision of current commissioning arrangements to address the inefficiencies of existing practices, as well as the sustained uncertainty that can result during contracting negotiations. There is the potential for greater efficiencies to be realised if the current short-termism of 111 contractual arrangements, which has tended to inhibit investment in this area, were addressed.

Furthermore, this would enable the integration of call handling and triage systems and processes, the consolidation of call handling and staff resourcing – with dual-trained staff strengthening system resilience – and the integrated management of patient flows across 999 and 111 patient pathways using interoperable platforms. There is scope to enhance the resilience of urgent and emergency care provision, the importance of which has been demonstrated throughout the Covid-19 pandemic.

From a system-wide perspective, commissioning the ambulance service at a combined STP / ICS level for these services, for a given regional geography, would leverage the ambulance sector's contribution to fully integrated urgent and emergency care, whilst ensuring the necessary oversight and scrutiny at an appropriate strategic level. This would also facilitate the inclusion of other activity undertaken by ambulance services, in relation to prevention and public health, for example, within strategic commissioning and contracting discussions and arrangements.

In alignment with the above, AACE would welcome consideration of the following principles:

- **Introduction of a single regional specification for integrated 999 and 111 provision sufficiently robust to strike the necessary balance between funding and need whilst ensuring a national standard with opportunity for localisation;**
- **Introduction of minimum five-year contracts for ambulance services to provide greater consistency and scope for realising trust, STP/ICS strategies and development and embedding of integrated 999 and 111 provision;**
- **Joint (and equal) strategic oversight by STP/ICSs within regions supported by strategic units undertaking contract management on behalf of STP/ICSs;**
- **Ambulance services not sitting inside any one STP/ICS control total given their provision of services within the footprint of multiple STPs/ICSs and the subsequent inappropriateness of financial alignment with just one (in accord with the above);**
- **The assumption of a central leadership role by NHS England/Improvement regional lead in line with the above and direction of travel outlined in the LTP.**

The regional footprint of NHS ambulance trusts underpins the unique role they have the potential to fulfil in the co-ordination of integrated 999 and 111 services, out of hours access, and clinical assessment services (CAS) to ensure the most appropriate response for each patient.

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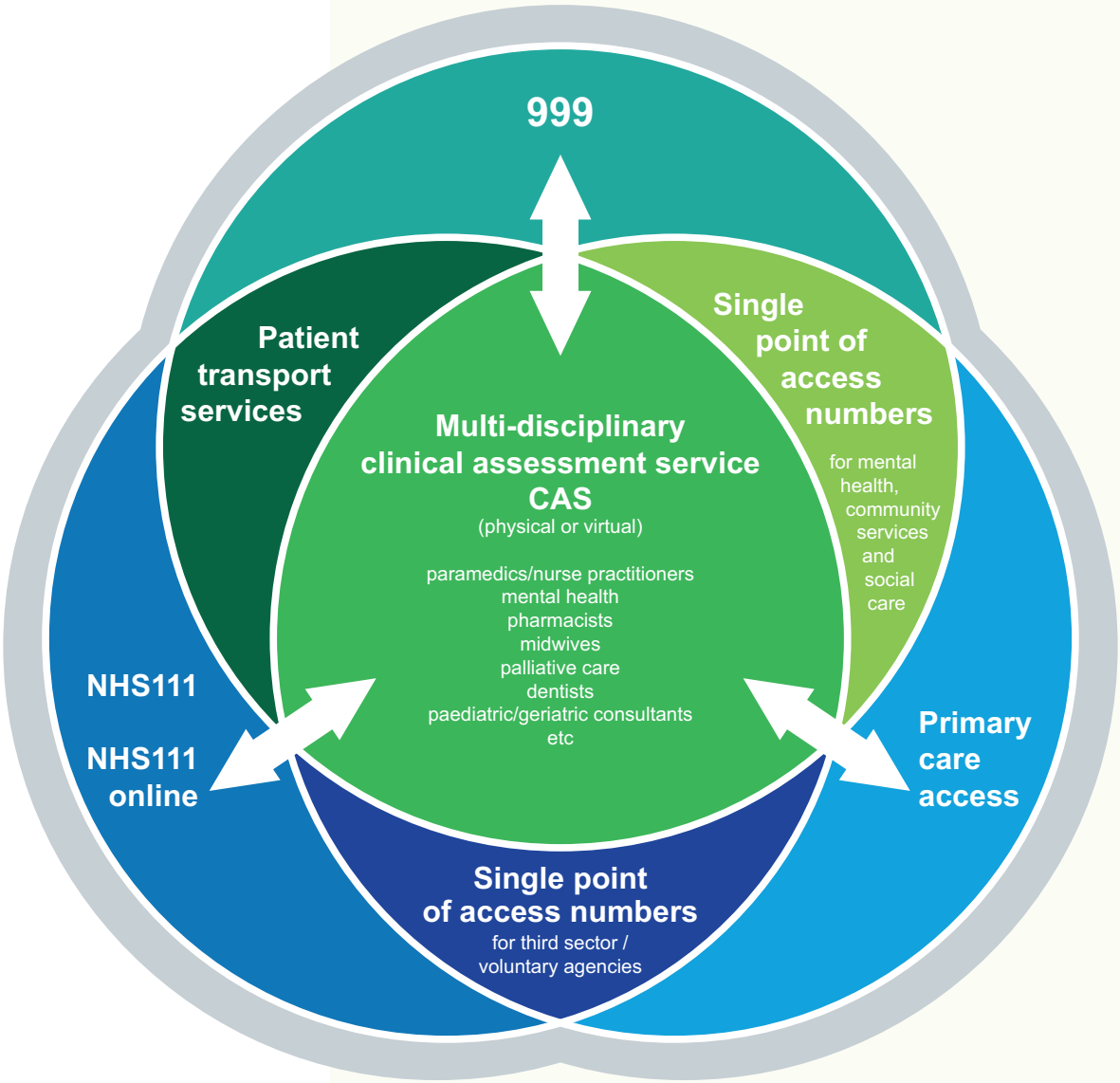
Regional single point of access model



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