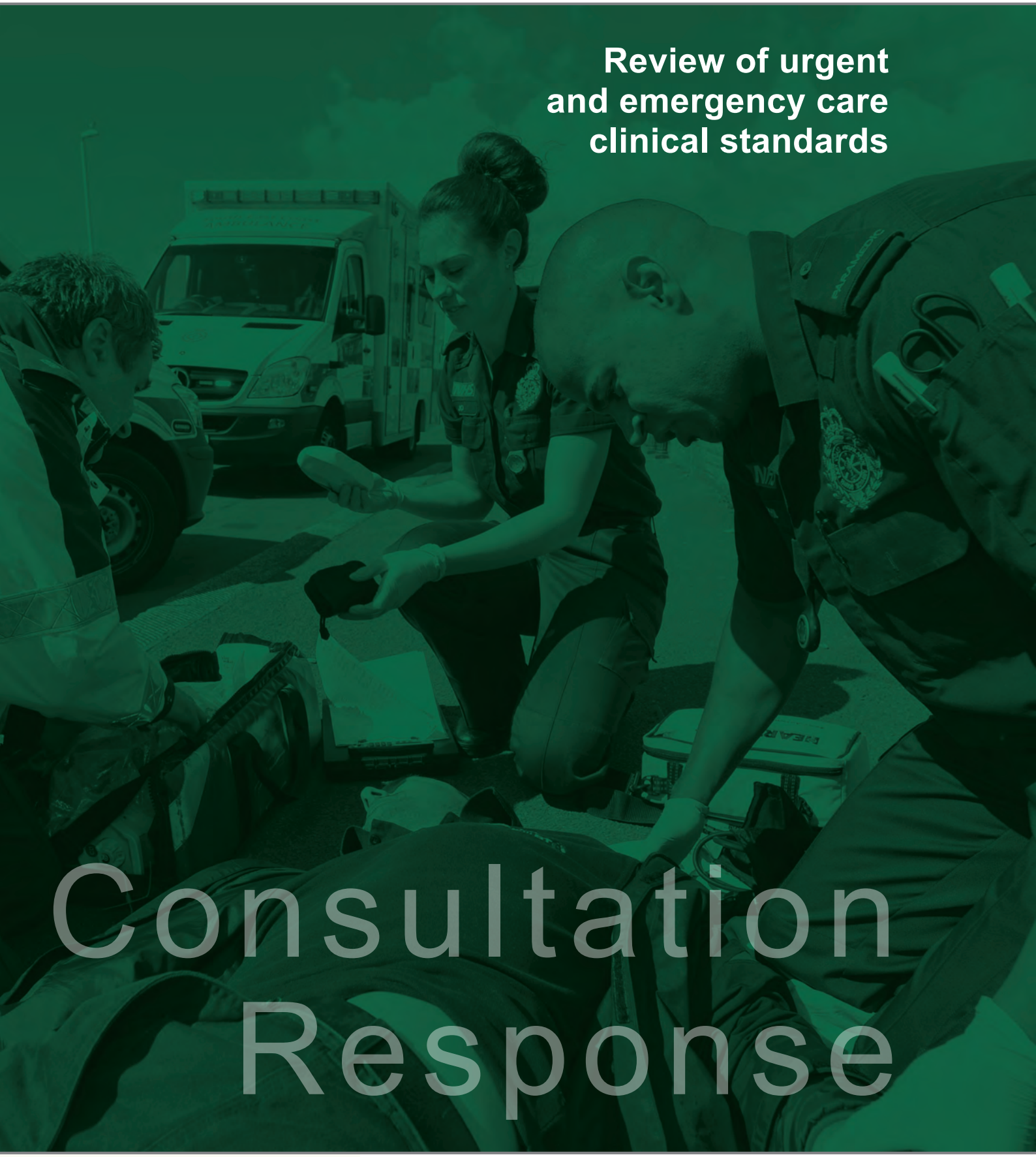
ASSOCIATION OF
AMBULANCE
CHIEF EXECUTIVES

Bringing together skills,
expertise and shared knowledge
in UK ambulance services

Review of urgent and emergency care clinical standards



Consultation Response

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Introduction

The Association of Ambulance Chief Executives (AACE) is a membership organisation that represents all UK NHS ambulance services. The majority of AACE's members provide either all, or a proportion, of 111 and patient transport services across their region as well as 999 services.

AACE welcomes the opportunity to respond to the final recommendations on the urgent and emergency care (UEC) standards from the Clinically-led Review of NHS Standards (CRS). This response has been developed in conjunction with the ten NHS ambulance services in England with input from chief executives, medical directors, quality and risk directors, operations directors, strategy and transformation directors and others. Trusts will also be submitting their own direct responses to the consultation.

We are supportive of the outlined intention to consider the patient journey in its entirety rather than primarily focus on care provided in the acute setting. As a sector, we welcome the opportunities this offers to improve patient flow and service user experience through a system-focused approach.

Given the role the ambulance service plays in the significant majority of patient journeys, through either 999 or 111, we occupy a unique position to advise on demand trends, patient flow, pathways, gaps in service provision and local variation. We were surprised that neither AACE nor the College of Paramedics were invited to contribute to the review. We are, however, very keen to respond directly to the consultation questions posed and to offer our ongoing support to NHS England and Improvement (NHSEI) throughout the remainder of this process to ensure the measures relating to the ambulance service, as well as the UEC system in its entirety, are realistic and meaningful.

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General feedback

Language and nomenclature

Our members commented that some of the language used in the document is rather out-dated and not aligned to the modern ambulance services they provide, delivering care across the UEC system; specific examples are referenced below.

- **'Prehospital'** is not a helpful term for the patient, ambulance service or wider system as it implies that all patients go to hospital with the ambulance service just being a precursor to that inevitability. The term 'prehospital care' is best used to refer to the cohesive care systems which provide critical care for patients with emergency care needs which cannot be met outside of the hospital environment and where care is literally provided 'pre' hospital, for all who survive to be transported. The term is largely used in this regard now in association with faculties rather than ambulance organisations.

- **'Conveyance'** is not always a helpful term as it can imply ambulance service transportation is required when it might not always be necessary or appropriate. For example, on p.19, the fourth option of non-ambulance transport is not mentioned at all when this may be a viable and appropriate way of travelling. We should not automatically see, or present, an ambulance as a mode of transport for anyone who cannot be managed with a home visit or telephone consultation. We also feel the term 'avoidable trips' is not appropriate and would welcome its revision.

- **'Getting the right vehicle'**, on page 36, is misaligned with policy direction of ambulance services being providers of urgent and emergency care. The primary emphasis should be on ensuring the right clinician with the appropriate equipment, rather than a mode of transport. We would strongly advocate a revision of this and, more generally, support moving away from conceptualising everything in terms of a vehicle rather than the clinical provision of care and effective patient-centred decision-making.

Context

Our members shared some contextual commentary with us referring to various parts of the document, as well as making other general points, which we would like to factor into our consultation response; these are raised below.

- Generally, whilst time targets are surrogates for patient safety and quality, we would welcome a move towards clinical outcome measures if inequity of access and variation of outcomes are really to be addressed; examples include:

    - A patient with a stroke needs to be at a hyper-acute stroke unit (HASU) well within 4 hours to minimise the long term impact – therefore the whole journey needs to be measured rather than individual sections eg. Cat 2 response;

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- Mental health patients should have equitable access to the right services - not be taken to an emergency department (ED) by default; a quality indicator would be how many mental health patients are seen only by mental health and are admitted to the appropriate bed within 4 hours;
- Others would be sepsis bundle, pain relief, pressure sores, discharge after admission within 6,12, 24, 48 hours as this may indicate a lack of community services.

- There are no reflections contained in the document on the challenges associated with recruiting paramedics or clinicians more widely – particularly within core clinical assessment service (CAS) and wider integrated urgent care (IUC) – which are very much a reality.

- The addition of the indicator for conveyance rates to ED is welcomed but there are concerns over demographic and deprivation variation in the context of a national target, and the availability of alternatives. We have received some feedback that there is a need to measure re-contacts formally, if ambulance services are, essentially, being encouraged to increase their risk tolerance.

- On p.21 video consultations are referenced, firstly, referral to clinicians in the urgent treatment centre (UTC) for a video consultation following referral from NHS111: this suggests that there is capacity in the UTC space to provide support to NHS111 or local CAS, which may not be the case.

  Secondly, 'where further clinical advice is required from secondary care during a face-to-face appointment, systems should be establishing referral pathways for access to a rapid video consultation with, for example, acute medicine, frailty services, Same Day Emergency Care (SDEC) and emergency medicine (EM) consultants': we question whether efficacy has been proven in relation to this (and would welcome assurance) and would also flag that capacity in acute medicine, SDEC and EM is already stretched; implementation of immediately available video-consultation in these settings would require considerable investment in increasing human resource.

- On p.28 it states, 'We are also exploring how NHS111 can help simplify the process for GPs, ambulance services, community teams and social care to make referrals to these services via a single point of access'. We would strongly advocate that ambulance clinicians need to be accepted as 'trusted assessors' with direct referrals to Crisis Response Services accepted (ie without the need to refer to a GP).

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RESPONSES TO ENGAGEMENT QUESTIONS

1.0 Are you aware of the existing Accident and Emergency four-hour standard?

1.1 Yes.

2.0 If yes, what do you understand the existing four-hour standard to mean?

2.1 An operational standard stating that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours; the target was introduced in 2004 aiming to improve the delays in care prevalent in the 1990s and setting a uniform expectation of service for patients in the UK.

2.2 Originally introduced with a target of 98% in the 2000s, the standard was relaxed to 95% in 2010.

2.3 The measure applies to Type 1-3 A&E departments (1 major A&E, 2 consultant-led single speciality units, 3 minor injury units and walk-in centres etc); for ambulance admissions the 'start' time commences at the point the patient is handed over to hospital staff or 15 mins after ambulance arrival (whichever is soonest).

3.0 Which would help you understand how well urgent or emergency care is doing: a single measure or a wider range of measures across your urgent or emergency care journey?

3.1 We would support the adoption of a wide range of measures, including clinical quality indicators (CQIs); as the bundle reflects the whole patient journey spanning from first contact through to discharge and the intersections between points of care, it enables both providers and health systems to understand performance and identify where transformation and further investment may be required.

3.2 A single measure is good to understand at a high level (eg whole-system) how we are performing as a collective (as well as potentially being preferable from a patient perspective) but granular provider level measures are still required in order to support specific provider performance monitoring against agreed standard; without provider-specific context, targeted initiatives to improve patient experience and outcome cannot be defined and implemented.

3.3 We feel the new standards are a positive step forward in connecting care pathways and services around the patient, but more can be done.

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4.0 Please rate how important you think each of the measures are based on a scale of 1-5, where 1 is not important and 5 is extremely important?

Measure	Rating	Rationale
Response times for ambulances	**5**	• An important measure (taking into account the varying categories) although this puts the focus solely on response times; just as important is the notion of taking the patient to the right place when this is needed, and ensuring patient safety, clinical quality and excellent patient experience • Response times are often influenced by a range of system factors including hospital turnaround times; understanding system-wide factors that influence this is therefore an important aspect of this measure • Fundamental to an emergency service for life saving care
Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances	**5**	• 'Trips' is not an appropriate term and we would welcome its revision (possibly journeys); we would also welcome this measure being preceded by 'safely': reducing conveyance is no good if it adversely affects clinical outcome for the patient • Supports the aspiration within the ambulance sector to increase the numbers of patients seen and treated without the need for onward conveyance – through utilising the experience and skills of our multi-professional workforce • Understanding and measuring clinical safety and effectiveness of conveyance reduction strategies is vitally important • Key to ensuring delivery of the right care for patients and ensuring operational efficiency by ambulance providers – targeting response and conveyance to those who need it most, and signposting to other services where more appropriate • Reduced conveyance supports system-wide efficiency and helps create capacity to treat those most in need, helping reduce delays etc. • Working definition of the term 'avoidable' is required for implementation, however, 'avoidable conveyance' is clinically subjective and difficult to measure in a consistently reproducible way • A standard for suitable alternatives to ED, rather than purely avoidable admissions, would reduce potential for focus on discharge at scene with no onward referrals – may not always represent safe, high quality care

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Measure	Rating	Rationale
Proportion of contacts via NHS111 that receive clinical input	**4**	• A helpful measure in understanding the limitations and constraints associated with non-clinician triage, particularly as the non-clinician outcome will often default to a higher level of care being requested including ambulance / ED disposition, placing increased strain on the wider system • Question whether, rather than the type of input, the focus should be on output – ie proportion transferred to 999, re-contacts, etc so we evaluate how the patient pathway involves mitigation and escalation to ED • Useful to understand in context of pre-999 triage where calls escalate to 999 from 111 environments; if clinical input at 111 triage stage can support avoiding referral to ambulance, this enables better patient care elsewhere in system • Need to be clear re the value of this measure – an increased proportion of patients calling NHS111 that require clinical assessment could be interpreted as a failure of the NHS Pathways algorithm
Percentage of Ambulance Handovers within 15 minutes	**5**	• We see this as a vital measure of system performance and safety, given its direct impact on ambulance availability – and subsequently response times – and ultimately, clinical outcomes, both for patients being looked after by an ambulance service crew as well as those waiting for an ambulance in the community • Hours lost to handover delays have a considerable impact on the availability of ambulance resource and a detrimental impact upon patients; delays prevent the occupied crew attending other patients with life-threatening illnesses or injuries; ambulance service dispatchers in emergency operations centres are left in a difficult position whereby they have no ambulances to dispatch to high-category patients and the number of calls waiting starts to increase • Understanding and actively managing the impact of hospital handover times on patient care is fundamental to improving patient experience and outcomes; reducing delays at handover translates into better care for those patients being handed-over whilst creating capacity in the 999 environment to ensure patients in the community receive timely responses • At a local level, how the system achieves this standard within local arrangements is important given its impact across the health and social care system for the reasons outlined above; however, the removal of financial sanctions relating to this measure are proposed in the 2021-22 NHS standard contract; clarity re accountability is subsequently necessary

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Measure	Rating	Rationale
Percentage of Ambulance Handovers within 15 minutes *Continued*	**5**	• In relation to all the ambulance service measures proposed, we would welcome a move to standards similar to those developed in the Ambulance Response Programme (ARP) (ie mean and 90th centile) otherwise excessive wait times, in which patient safety is compromised, could be hidden in the 'tail of performance'; we would also include a measure of the longest wait times
Time to Initial Assessment – percentage within 15 minutes	**3**	• Important as a safety measure for a limited subset of patients with potential life threatening illness • This measure will directly support a reduction on handover delays whilst also contributing to a system-level view; improving this measure will influence improvements in system capacity and flow, leading to improved patient outcomes • The majority of our members view this as a critical safety standard • Ambulance providers will directly influence this measure through their conveyance rates but cannot influence compliance with the measure once arrival has been confirmed • As for the previous measure, we would recommend consideration of a centile measurement as averages can hide the outliers; this would be in line with ambulance services measurements (as included in the ARP) • Need to clarify the 'clock start' for this measure; we believe it should be the time of arrival of the ambulance, and should mirror the ambulance handover measure
Average (mean) time in Department – non-admitted patients	**4**	• Only useful alongside the long wait metric • Minimal impact on the ambulance service, other than as an indication of patient flow, unless directly linked to ambulance arrival time • Measure contributes to system level view of efficient patient treatment, and is linked to patient flow and impact on capacity; in isolation, may be of limited value but when combined with other measures, helps paint a picture of factors negatively influencing efficient system flow / capacity • Some patients can wait longer than others, critical element here is not penalising those who spend longer to avoid a potential admission which is worth the outcome • As above, we would recommend a centile measurement as averages can hide the outliers and would be in line with ambulance services measurements

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Measure	Rating	Rationale
Average (mean) time in Department – admitted patients	**4**	• Only useful alongside the long wait metric • This has minimal impact on the ambulance service, other than as an indication of patient flow unless this is directly linked to the ambulance arrival time • This measure contributes to a system level view of efficient patient treatment, and is linked to patient flow and impact on capacity; in isolation this may be of limited value but when combined with other measures it helps paint a picture of factors negatively influencing efficient system flow / capacity • It would be useful to understand how many patients leave hospital after arrival at ED without further treatment provided; this would support potential to further understand why those patients are being conveyed, and identification of alternatives • Admitted patient flow – if performing well – decompresses the whole ED and reduces further onward risk
Clinically Ready to Proceed	**4**	• Potential risk: standards for assessment can be misinterpreted • Flow and throughput of patients is important in reducing handover delays; applicable to ED and the wider hospital • This measure contributes to a system level view of efficient patient treatment, and is linked to patient flow and impact on capacity; in isolation this may be of limited value but when combined with other measures it helps paint a picture of factors negatively influencing efficient system flow / capacity • Need to clarify if this will be subject to local interpretation eg 'medically fit' or 'medically optimised'; definitions are crucial here
Percentage of patients spending more than 12 hours in A&E	**4**	• Important as a contributor to measurement of patient experience • Minimal impact on the ambulance service, other than as an indication of patient flow • Very long waits need a transparent measure; significantly more informative than the current 12hr trolley wait • Measure contributes to a system level view of efficient patient treatment, and is linked to patient flow and impact on capacity; in isolation this may be of limited value but when combined with other measures it helps paint a picture of factors negatively influencing efficient system flow / capacity

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Measure	Rating	Rationale
Percentage of patients spending more than 12 hours in A&E *Continued*	**4**	• 12-hour waits, although undesirable and of detriment to patient experience, do not represent the whole picture and help identify issues within systems and create focus for recourse; this measure does not take into account particular patients, such as those with social care rehabilitation needs, or with mental health, where a package of support services may be needed to support discharge or inpatient treatment
Critical time standards	**5**	• The critical time standards will help us to improve the quality of care for life-threatening conditions, with the aim of saving more lives and reducing avoidable morbidity – at all stages of the system; we support the focus on the delivery of evidence-based clinical interventions • Ambulance services play a vital role conveying specific cohorts of patients (eg stroke, heart attack and trauma) and utilising the most appropriate care pathway; it is important these patients are appropriately managed from the moment 999 is dialled and these arrangements are factored into the bundle of measures • Difficult to score these without seeing them in detail; principles align to ambulance CQI outcomes and care bundles of ensuring patients receive the interventions needed for their conditions across entire care pathway • Vital to understand an holistic system-view, but requires the underpinning 'per provider' metrics to support individual providers to understand their contribution to system effectiveness • Measure is equally as important as ambulance response time to patient side • Important but the composite scoring system means that all questions are weighted equally and this may not be appropriate for this criterion

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5.0 Are there any additional measures that should be included within the bundle?

5.1 There are no patient outcome-based measures in these indicators; nothing currently measuring the 'right care' element of right care, right time and right place, which we view as essential.

5.2 There seems an overt focus on inputs and less on outcomes; more holistic indicators reflecting community services would be useful too.

5.3 The proposed bundle presents a risk that acute trusts will choose to 'hold' patients in ambulances in order to preserve the binary scores of other measures which would be a dangerous unintended consequence for patients.

5.4 Provided below are areas that our member services would like to see considered as additions to the bundle – with some variation captured from different ambulance services.

5.5 One of our member trusts would advocate consideration of inclusion of measurement of the following elements (in order of importance):

- Demand from pharmacies, GPs and care homes eg referral to 999 or A&E that conclude with avoidable ambulance / attendance / admission
- Conveyance to the most appropriate care pathways would be a stronger indicator than simply reducing conveyance to ED; this would demonstrate performance on achieving mental health / stroke / fall outcomes; an appropriate form of measurement would need to be determined
- 111, CAS priority response times in addition to the % reviewed by clinician; providing a focus on capacity meeting demand
- Time to handover for pre-alert priority (blue light) hospital transfers (15 minutes too long)
- % of patients that attend EDs following some form of clinical assessment or triage (ambulance, 111, GP, etc.)
- Ambulance call cycle times
- % of alternative care pathway (ACP) referrals placed vs ACP availability
- Ambulance service re-contact rates following non-conveyance (surrogate measure of safety)
- Recording times at ED – the time a patient leaves a department needs to be recorded rather than decision to admit
- Re-attendance / readmission rates

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5.6 Another ambulance service has highlighted the need for consideration of the following, which would also be welcomed in support of the broader population healthcare management agenda: discharge wait time eg time taken from point of discharge being agreed, to actual discharge from care (links to flow and capacity to treat more patients), measure of patient re-admission rates within X hours for any reason, 111 referral rate for ambulance response, call pick-up times, morbidity rate at XX days from discharge.

5.7 Other suggestions from our members include the following:

- Numbers left without being seen in EDs
- A measure capturing primary care access
- Something capturing availability and responsiveness in social care
- Time to clinician was always a close 2nd behind the equivalent of clinically ready to proceed in terms of reasons for delays
- Out-of-hospital / ambulance environment indicator – the conversion of NHS111 referrals to 999, which would demonstrate whether clinical decision making is effectively identifying and managing acuity
- Proportion of 999 contacts that receive clinical input (the proposed standards cover 111 but not 999, this is important in reducing avoidable 'trips')
- The number of appropriate patients that are managed by 999 clinicians on scene and who are not transported to ED
- Percentage of patients passed to SDEC or CAS systems
- A centile measure to accompany the mean time in ED measures

6.0 To what extent do you agree with the recommendation to replace the current measure with the proposed new bundle of measures?

6.1 We agree with the recommendation to replace the current measure with the proposed new bundle of measures with the caveat that the targets are realistic, there is a greater focus on clinical outcomes and quality, and that there is close engagement with the ambulance sector in setting the parameters.

6.2 The move to more formalised ICSs supports bringing together a bundle of measures that report on system level performance; for patients this should give them an overall view of their system whilst also enabling them to understand what to expect from an individual provider when receiving care or treatment.

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6.3 A whole system view of performance is not currently shared and doing so will support wider collaboration with a view to improving patient care; clear visibility of performance issues across these metrics will support providers to target improvement activity where needed (eg 999-hospital handover delays).

6.4 We also believe careful consideration needs to be given towards the approach of performance management at ICS level; to cite an example provided by one of our member trusts, with five ICSs in London (one per 'sector'), this would present an operational challenge and potentially increased operating costs to move to delivery of ICS level performance as opposed to currently commissioned regional level performance for ambulance services; furthermore, it does not support the integration of UEC (111 and ambulance services) at a regional level which aims to deliver both improvements in service quality and a potential reduction in operating costs achieved only through operating at an increased scale.

6.5 We welcome the replacement of the 12-hour trolley wait standard and the introduction of the clinically ready to proceed time, however, the 4 hours standard when complied with inherently meant both were essentially having to be managed.

6.6 To reiterate, the 'Clinically Ready to Proceed' measure would need clear definition as this could be very subjective in terms of interpretation and result in inconsistent / inaccurate reporting and confusion.

6.7 There needs to be an acknowledgement that systems and partners will require time to achieve the measures and we would therefore recommend a trajectory for improvement / achievement.

7.0 To what extent do you agree that measuring the average time for all patients is a more appropriate or meaningful performance measure than the percentage of patients treated within a pre-determined timeframe?

7.1 We agree that measuring the average time is more appropriate; this is consistent with the ambulance performance standards which moved to the average time when ARP was introduced in 2017; we would welcome consideration of introducing a 90th centile performance measure too.

7.2 Measuring the average time for all patients gives a clearer picture of the patient journey at each stage of the system; if average times begin increasing, it highlights that patients are spending longer in the system and that there is an issue that needs to be addressed.

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7.3 This change would mean that every patient counts towards performance standards, resulting in overall improvements to patient experience and outcomes; the adoption of this approach with the introduction of the ARP standards has had a very positive impact.

7.4 Certainly an improvement – currently performance reporting can mask how challenged some hospitals, and systems as a consequence, really are.

8.0 To what extent do you agree that the bundle of indicators adequately measures the elements of the Urgent and Emergency Care pathway that are important to you?

8.1 We agree to some extent; the elements selected provide the beginnings of a relatively good range across the UEC pathway, and include elements which can have a direct impact on ambulance services at both ends of the journey, ie calls from NHS111, handover delays and patient flow.

8.2 However, we would welcome consideration being given to revision of ambulance CQIs given their current focus on higher acuity patients, which does not reflect the majority of the patients we attend; we suggest modification so they better represent the proportion of urgent care patients, which compromises the majority of our work (eg. 65% for one member trust).

8.3 The bundle is primarily focussed on the emergency component of UEC services; further consideration of appropriate measures for the urgent care components, eg. use of alternative care pathways including UTCs would be welcomed.

8.4 We would also like to suggest consideration of the development of metrics to measure the scale and impact of public health / education messaging for urgent and emergency care.

8.5 Need to be mindful that the A&E CQIs, developed in 2010/11, were never seemingly mainstreamed; need to understand why that was, and learn the lessons so that the identified issues do not affect this bundle.

8.6 Keen to see the critical time standards set out in detail.

8.7 Further consideration must be given to the 'tail of performance' to fully understand overall performance.

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9.0 Please explain why you think the measures identified are appropriate or not?

9.1 We believe the measures are mostly appropriate (with the inclusion of additional measures stated above) as they will offer an end-to-end view of performance across the UEC pathway, highlighting critical pressure points that require immediate actions and longer term transformation.

9.2 The proposed measures give a collective system view; linked to proposed changes in commissioning towards the formalised ICS model, these changes will ensure collaboration and true system-driven care decisions are made for the purposes of improving patient outcomes.

9.3 The bundle includes most of the key elements in the patient journey, with the additions suggested in previous answers; the 'avoidable trips' measure is dependent on the services (other than ED) that are available in the local area eg safe places for a mental health patient are scarce and ambulance crews have to travel long distances to an appropriate unit; this needs to be understood.

9.4 We are keen to understand how this bundle of measures will be implemented and what the implication of poor performance will be.

10.0 What do you think are the best ways to advise and communicate the proposed new urgent and emergency care measures to patients and visitors to urgent and emergency care departments?

10.1 This could include information published on websites, apps and communication through the media, along with the information provided in UEC departments; patient focus groups, social media platforms, statutory consultation if appropriate, range of stakeholder events, printed materials etc.

10.2 We believe it is important to acknowledge the impact that public education could potentially have on UEC, as well as the need to be able to measure the effect of public engagement.

10.3 To have the biggest impact, key messages should be targeted towards patients in a primary care setting (not just in UEC departments), where they are likely to spend time in waiting rooms and see posters and TV adverts; we would recommend a joined-up approach, reinforcing messages at all levels on public websites; acute trusts, ambulance trusts, mental health trusts, community health trusts; NHSEI could also cascade information down to NHS trusts for consideration by Public & Patient Councils, Healthwatch and other relevant stakeholders.

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10.4 One of our member trusts engaged with its Public & Patient Council in relation to this question: they were of the opinion that clear and targeted communications are key; they felt it was essential that members of the public are educated on how to effectively access the healthcare system so there is better understanding of the benefits of care models and ways of working; key enablers are investment in education as well as measuring success linked to public education campaigns; feedback included alternative healthcare routes being introduced during the pandemic and public behaviour changing quickly during a crisis; they stressed that we have seen a radical shift and now is the time to educate people and strengthen understanding of healthcare options so they do not fall back to old habits of immediately dialling 999; we support these views, especially with regard to embedding recent developments associated with NHS111 and also the increased use of video technology and phone consultations.

10.5 Use of pathway / journey of care analogy and the various points in that pathway being measured - would lend itself to a good pathway or timeline image.

10.6 Question the extent of the mainstream public's interest in internal measurement – may be more focused on workforce and infrastructure growth and personal experience.

10.7 Essential to keep public communications as simple and clear as possible for the majority of the public, as demonstrated in relation to Brexit (ie. resonance of 'Get Brexit Done' in 2019 election) and COVID-19 'hands, face, space'.

10.8 Greater consistency and care of language required (as highlighted earlier):

- Ambulance will 'send' the right response – it may be interpreted as everyone receiving an ambulance when they call 999
- 'Right vehicle' – must consider the right skills on the vehicle to make effective, patient centred decisions

11.0 What are the key issues / barriers that should be taken into account for implementation of the bundle of measures and establishing thresholds for performance? What additional support might providers need for implementation?

11.1 Issues and barriers:

- **Commissioning arrangements:** ambulance services are commissioned for performance standards at a trust level; therefore each system covered would need to report the overall trust; reporting performance at the system level could penalise the system performance based on the trust's commissioning arrangements

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- **Unintended consequences:** potential issue is the unintended consequences of changing the measures to average times, particularly in relation to the potential for patients who are quick to treat being prioritised over those who are likely to take longer; furthermore, suggested proposal presents a risk that acute trusts may choose to 'hold' patients in ambulances to preserve the binary score of other measures – needs to be considered with the 'arrival time'

- **Required enablers:** the aim of ARP was to move away from time targets to outcome data for all patients; this can only be done with the further development of ambulance care data set and emergency care data set programmes; we strongly support a focus on patient outcome data in relation to developing alternative responses – alongside ambulance responses eg mental health cars, falls and advanced urgent care paramedics

- **Same Day Emergency Care:** if ambulances are to directly access SDEC we would suggest that the admission criteria is based on symptoms rather than differential diagnoses; we would also recommend avoiding multiple handover points and to avoid patient booking at reception

- **Access to pathways:** ambulance services, GPs and 111 need to have direct access to all pathways and services; this should not be limited to a certain number or require booking in via the ED first otherwise ED, once again, becomes the default; we believe pathways and services would benefit from being designed / enhanced using a collaborative approach

- **Reducing avoidable trips (conveyance rates) to EDs:** many appropriate care pathways are only available during daylight hours; they have not been built or commissioned for wider 999 demand; we believe the system as a whole – with patients at its core – would benefit if further investment was made in alternative care pathways to help ease capacity issues and to ensure patients receive the most appropriate care 24/7

- **Conveying vehicle:** on p.20, we would question whether performance metrics which rely on 'the' conveying vehicle truly measure what is clinically relevant; in most cases, the time to clinical assessment is the clinically relevant factor; the arrival of the conveying vehicle is relevant only once it is established a journey in an emergency ambulance is required

- **Social care & community services:** firstly, we strongly believe that the exit block from EDs will only be resolved by investing in social care and community services; this will improve patient flow, increase capacity and help patients to move back into the community with appropriate support; secondly, there are significant requirements around directory of services (DoS) (national and local) – needs assurance that these are developed consistently and collectively

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- **Workforce:** as referenced previously, there is no acknowledgment or recognition of the challenges associated with recruiting paramedics, nurses or other clinicians for the UEC environment – particularly within core CAS and wider IUC / local CAS and UTCs / SDECs; ambulance clinicians need to be accepted as 'trusted assessors', with direct referrals to crisis response services (bypassing need to refer to GP)

- **Data sharing:** data for certain patient groups, eg cardiac arrest and stroke patients, is currently uploaded but ambulance services have limited access to patient outcome data; a number of web portals are used for this process and we would recommend careful thought is given towards streamlining the process of data collection from ambulance trusts and hospitals (for the new bundle of measures) so that the whole patient journey is reflected in one system; this would facilitate greater collaborative working so we can identify issues and opportunities for innovation

- **Current lack of clarity:** ambulance services will need a greater understanding of the potential impact of service redesign that this change might bring and subsequent understanding of implications to resource levels to meet demands across the system; also required is an appropriate process review to ensure the most effective care is delivered to support the model (eg is it appropriate to send the nearest available resource to meet a time-bound metric, or to send the most appropriate resource instead)

- **Learning:** as referenced previously, lessons need to be learnt about why the clinical quality indicators launched by Andrew Lansley were not effectively mainstreamed; need to ensure that does not happen again

- **Process changes:** these will be required to operational data capture and reporting processes as well as consideration of the implications of the NHS Standard Contract; gaining a clinical consensus on the thresholds will also be necessary

- **Maximising use of video / remote consultation:** would welcome assurance that efficacy of approach is proven; question capacity for rapid assessment / consultation – ongoing challenges in recruitment and coordination; consideration needs to be given to dis-enfranchised groups and equity of access

11.2 Additional support:

- **111 development and funding:** if 111 is to continue to develop as the single point of access, which we support, a stepped increase in investment is required

- **Expanded digital support:** required for information sharing, as well as clinical assessment using video consultation and outcome data

- **Digital consultation:** additional funding is needed to enhance and expand existing technology allowing digital consultation to be developed in 111

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- **Patient data:** to ensure measurement of what is clinically relevant and to shift the focus from time targets towards patient outcomes, we would support greater investment in ambulance service clinical audit and research teams; this would allow for whole system data monitoring of the patient journey to include additional patient groups such as fallers and those with mental health concerns; patient data is a valuable commodity and system partners must work closely with NHSEI, setting up data sharing agreements where necessary to be able to learn from the whole patient journey to improve patient care

12.0 Do you support the idea of a composite measurement approach to presenting the effectiveness of urgent and emergency care across a system? This aligns with the approach for national ambulance reporting, using a balanced scorecard of all indicators but with an aggregate numerical assessment based on achievement.

12.1 The composite measurement is a good idea to simplify and aggregate to obtain a system performance; we require further clarity on how the composite measurement approach would be used in the performance management of a provider to be able to comment definitively.

12.2 Composite dashboard will provide useful overview of UEC performance to systems and places; scorecard will need to be supplemented with other measures particularly related to flow and discharge.

12.3 In relation to the composite measurement, if the composite is made up of ten binary pass / fail metrics, it will not be a sensitive measure to identify trends (improvement / deterioration in performance), which could limit its operational value – it would be more valuable as a public communication tool; clarity is required about how the composite measurement will be used, what the thresholds are, and what underpinning metrics will be used to supplement these ten measures.

12.4 The potential issue of the proposed composite measure is that it is too simplistic and suggests that each measure will be a pass / fail and be scored 0 or 1 accordingly.

13.0 How frequently should this composite be updated and published?

13.1 We would support an annual update of the composite to allow for agreed adjustments to be made to any of the measures as required; for example, this might involve adjusting the thresholds / targets as commissioning priorities change.

13.2 Performance composites should be published quarterly, but monitored at a system level at least monthly to ensure a swift response as needed to effect changes to improve patient outcomes.

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