Service Specification No.	QVV/0277
Service	Urgent and Emergency Ambulance Services
Commissioner Lead	Dorset CCG
Provider Lead	Executive Director of Operations – SWASFT
Period	1st April 2022 – 31st March 2023
Date of Review	1st October 2022

1. Population Needs

1.1 National/local context and evidence base

Ten Ambulance Service Trusts provide emergency and urgent care services for 54 million people in England. In addition, the Welsh Ambulance Service, Scottish Ambulance Service, and Northern Ireland Ambulance Service provide care for Wales, Scotland, and Northern Ireland respectively. The Isle of Wight is managed under a separate arrangement.

Demand for these services has grown consistently over the past 15 years and continues to do so. Trusts are also seeing a rise in the clinical acuity of patients presenting via 999.

The combination of the 999 and calls from NHS 111 Services means that UK Ambulance Service Trusts are now the providers of 11 million episodes of care each year. The need to provide enhanced triage and clinical decision making in Ambulance Contact Centers is crucial in the context of the national policy drivers set out in the NHS Five Year Forward View (5YFV), Carter Review and Long Term Plan.

Contraction in available funding to support growth and the delivery of cost improvement programmes is driving a more radical approach to service delivery change, requiring Ambulance Services to reconsider their service delivery models in order to both meet the current financial and demand pressures and to position themselves in a strategically strong position in order to be responsive to changes occurring across the region.
The Urgent and Emergency Care Review published in 2013 and updated in 2015 set two primary objectives:

- For those people with urgent but non-life-threatening needs we must provide highly responsive, effective, and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.

- For those people with more serious or life-threatening emergency needs we should ensure they are treated in centers with the very best expertise and facilities, in order to maximise their chances of survival and a good recovery.

It is important to recognise that the 999 service is part of the wider NHS system providing integrated patient care and should be commissioned as such.

Provision of 999 services is aligned closely with national and regional initiatives driven by:

- Sustainability and Transformational Partnerships.
- Integrated Care System.
- Integrated Urgent Care systems (i.e. NHS 111, Clinical Assessment Services, Urgent Treatment Centres, GP Out of Hours Services, etc).

Additionally, regional Ambulance Trusts may collaborate closely with other ambulance services, the wider emergency services or wider system providers to deliver appropriate patient care.

To support the service transformation agenda, the key requirements are:

- To deliver the core response and clinical outcome standards as defined by the Ambulance Response Programme.
- To fulfil statutory duties relating to emergency preparedness, resilience and response (EPRR).
- Optimisation of call handling and appropriate responses through virtual alignment of NHS 111/999 and call/ CAD transfer between ambulance services.
- Increase the percentage of lower acuity calls managed through “hear and treat” and “see and treat” options.
- Utilise a virtual delivery model to support wider workforce integration for paramedics, call handlers and specialist staff with local urgent care delivery models.
- Facilitate cross boundary working and the flexible use of ambulance service resources to support the development of regional Sustainability and Transformational Plans and Integrated Care Systems.

This new Service Specification has been developed collectively with commissioners and providers of Paramedic Emergency Services. NHS England will continue to work with commissioners during the implementation and delivery

of the Specification. Schedule 2 is primarily based on the new national specification, with local adaptation/additions where appropriate.

The 999 service is free for the public to call and is available 24 hours a day, 7 days a week, to respond to the population of England with a personalised contact service when patients:

- Require rapid treatment and in some cases transportation with life threatening illness/injury or emergencies (category 1 & 2).
- Present with lower acuity urgent and less urgent conditions (category 3 & 4) requiring clinical interventions.
- Patients may be passed to 999 via other NHS health care systems, including NHS 111.

The Provider is to provide Accident & Emergency ambulance services to all potential patients resident in, visiting, or travelling through its geographical area of responsibility namely Bath & North East Somerset, Swindon and Wiltshire, Bristol, North Somerset and South Gloucestershire, Devon, Dorset Gloucestershire, Somerset and Cornwall & the Isles of Scilly.

Accountability for the commissioning of the service lies with all CCGs, coordinated by Dorset CCG as the Coordinating Commissioner.

2. Outcomes

1.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

The provision of a high-performing, safe and effective 999 service can be mapped to the domains within the NHS Outcomes Framework.

CCGs are required to commission a service based on the Ambulance Response Programme model that prioritises 999 calls into four new categories:

1. Category 1 – Life threatening
2. Category 2 – Emergency
3. Category 3 – Urgent
4. Category 4 – Less Urgent

As the Integrated Urgent Care Service model becomes embedded this will support ambulance services to further develop “hear and treat” and “see and treat” models.

2.2 Local defined outcomes

As well as the common set of outcomes above, commissioners may consider and, in agreement with the Provider, define additional local outcomes depending on local demographics and need.

Additional locally agreed outcomes are set out in Schedule 4.

3. Scope

To meet the combined challenges of the safe management of high acuity patients, who make up a minority of activity, whilst also addressing the needs of the larger volume of mid and low acuity patients, against the backdrop of a finite funding position, Ambulance Services and Commissioners understand and recognise the need to work differently.

This will require a coordinated programme of service transformation, working to a common framework that delivers all key principles of patient care.

This five-stage framework will provide a structure through which ambulance services and commissioners can work together to deliver the principles of the 5YFV, Urgent and Emergency Care Delivery Plan, Carter Review and Long Term Plan. It places an emphasis on early clinical decision making that will ensure the delivery of care is commensurate with the clinical needs of our patients. Within each of the five elements, Trusts will need to deliver against mandatory expectations, whilst maintaining local autonomy that reflects the different patient and geographical demographics across the UK.

3.1 Before the call

The aims and objectives of the service before the call include any strategies to better manage potential patient demand by:

- Follow the principles of the NHS Constitution and engage with Public Health England to provide public education and guidance regarding the appropriate use of 999 ambulance services.

- Activity management through education and management of known high intensity users, both individual patients and care establishments such as nursing homes and hospitals.

- Use of tools and systems to accurately assess response against the clinical needs of patients referred by Healthcare Professionals.

The provider must be resourced and supported to engage in activities to assist in partnership initiatives that lead to better education and health management of the population and patients and ensure the best use of the services. Such initiatives may be the subject of local initiatives or be commissioned directly according to local requirements.

3.2 Answer my call

Answering the call involves better prioritisation and management of 999 demand and those NHS 111 calls that are passed to the ambulance service for a response through:

- Provision of clinical advice as soon as possible in the 999 call process (either by a clinician or a clinical based system applied by a non-clinician).

- Provision of clinical support hub functions in Emergency Operations Centres / Clinical Co-ordination Centres. Defined by the provider as Clinical Hubs.

- Apply best practice in line with national guidance to provide clinical intervention and validation of patients accessing 999 care via NHS 111.

The Provider will deliver the following response services every day of the year on a 24 hour basis for the following response services:

- 999 response (including Healthcare Professional Activity).

- Emergency Operations Centres / Clinical Co-ordination Centres.

- HART and similar services to support EPRR (Such services are detailed separately in accordance with the current published National Specification).

The service is provided for people with life threatening emergencies and urgent health care needs. It is accessed through the following routes:

- Direct access via a 999 call for ambulance service assistance by a person who is in the geographical area of the NHS Ambulance Trust.

- A request from a Healthcare Professional for the urgent transfer of a patient to a healthcare setting on the grounds of an urgent clinical need, such as medically expected patients who have been assessed by the HCP and require transportation to an acute facility within specified timescales, for a person who is in the geographical area of the NHS Ambulance Trust.

- Police and / or Fire Service Computer Aided Dispatch (CAD) Link or direct line for a person who is in the geographical area of the NHS Ambulance Trust

- NHS 111 calls passed to the 999 Ambulance Service, for a person who is in the geographical area of the NHS Ambulance Trust.

During periods of increased service pressures, the Provider will operate in accordance with locally agreed REAP escalation levels. Where appropriate, this will include clinical or operational support facilitated by the local Commissioner from other Health economy providers.

The Provider is to assess and triage all calls, using an accredited triage tool to assess the required response, as received from the public via the 999 telephone system and calls received from Healthcare Professionals and other emergency services, utilising an approved IT system in accordance with guidance published from time to time by NHS England. The provider will ensure that telephony systems are fully compliant with Ambulance Service Trusts position as a CAT1 responder under the Civil Contingencies Act.

The provider must have backup systems in order to continue operations in the event of a failure of the main IT system.

3.3 <u>Provide the right care</u>

Providing the right care, in the right place, and at the right time ensures that Ambulance Trusts appropriately assess patient needs and provide the most appropriate response in a timely way. This response may not be an emergency ambulance and could include:

- Embedding the Ambulance Response Programme principles into the EOC / CCC call management service.

- Utilising Pre-Determined Attendance (PDA) recommendations against the existing operational response model.

- Streaming appropriate patients and clinical advice calls to the wider healthcare system, using properly integrated technical systems.

A patient triage, either by telephone or face to face, will be undertaken by an appropriately qualified person. The triage event will be documented on an Electronic Patient Report (EPR) record or a paper record if EPR is not available or in the case of telephone triage, the Computer Aided Dispatch system. Where an EPR is not available plans must be in place to implement an EPR. Following an appropriate assessment, immediate and necessary interventions will be undertaken to preserve life where possible and support a person's clinical condition.

The Provider will ensure patients receive appropriate interventions as follows:

- **Hear and Treat / Refer**: Incidents with no face to face response. Calls will be managed by an approved triage system, and in cases where it is required, by registered clinicians working on behalf of the Clinical Hubs, resulting in no resource (vehicle) arriving at the scene. Hear and Treat / Refer service is to be available and staffed with appropriately qualified staff 24 hours per day. A successfully completed call is one where advice has been given with any appropriate action being agreed with the patient and where no further response is required from the ambulance service. Appropriate action may include telephone advice and 'signposting' or referral to any appropriate service such as GP, Out of Hours Service, Urgent Treatment Centre (UTC), Pharmacy, NHS 111, CTA etc.

- **See and Treat**: Calls which resulted in an emergency response arriving at the scene and where following assessment and / or treatment no onward conveyance was required (but with advice and appropriate 'signposting or referral to alternative services).

- **See and Convey**: Calls which result in an emergency response arriving at the scene, followed by ambulance conveyance to a healthcare facility. If there have been multiple calls to a single incident, then only 1 (one) incident should be recorded. Through the Ambulance Quality Indicators ambulance services are required to distinguish between conveyance to a type 1 or 2 ED and conveyance to an alternative service.

Local Commissioners, working with the ambulance service, will determine targets for “Hear & Treat” “See & Treat” and “See & Convey” subject to guidance issued by NHS England.

The provider is required to implement key clinical quality care pathways, e.g. those relating to falls, sepsis, mental health and others as they become available and are set out nationally.

The Provider will supply provision of an appropriate response to calls by suitably qualified staff in a suitably equipped vehicle if required, to meet the needs of the patient and the requirements of any applicable national quality standards. An appropriate response may include a trained community first responder, or a healthcare professional equipped with a defibrillator, paramedic, Nurse. Doctor, Specialist Paramedic - Urgent and Emergency Care, air ambulance or other appropriately trained and accountable responders able to deliver care and discharge at the scene, or transport to a healthcare facility or effect clinical triage and discharge. Where the first responder is a community first responder responding to a Category 1 call a backup ambulance/RRV or other appropriate Trust resource must also be activated.

The Provider will aim to ensure that each emergency unit/vehicle has a minimum of 1 registered clinician. If circumstances dictate that this is not the case and a vehicle does not contain a clinician, ambulance practitioner, technician or advanced technician the vehicle will be dispatched according to current SWASFT deployment guidelines of non clinical/Emergency Care Assistant crews.

Referral and discharge processes

The Provider is to follow locally agreed guidelines, including where deemed appropriate, those from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).

The Provider will, when clinically appropriate, transfer patients to the nearest appropriate Emergency Department (ED) except in the following circumstances:

- Specialist cases, for example trauma and heart attacks
- In extenuating circumstances where the patient requests transfer to an alternative ED. The decision will be agreed in liaison with the senior clinician on the vehicle.
- Where two EDs are equidistant the decision will be made by the senior clinician on the vehicle.

3.4 <u>Respond to my need(s)</u>

Responding to my need(s) includes:

- Using an NHS Accredited triage system to undertake call prioritisation linked to Pre-Determined Attendance methodology to establish the right response for every patient, first time, in order to reduce 'over responding' and improve utilisation.

- Subject to local determination, providing remote advice for responding staff to enable patients to be managed safely either in, or close to their home environment, wherever possible.

- The Provider will have appropriate mechanisms in place to access available electronic plans of care and these will be routinely shared with clinicians operating in the Provider's Services. The Commissioner working with clinical leads is responsible for making care plans available and for ensuring these are relevant and up to date.

- Using lower acuity accredited transport options, where it is safe and appropriate to do so.

The Ambulance Response Programme places an emphasis on making sure the most appropriate clinical response is provided for each patient first time and every time.

Ambulance services are measured on the time it takes from receiving a 999 call to a vehicle arriving at the patients location. Under the new national performance standards there are four categories of call which acknowledge that many patients do not require an immediate response. However those that do will be prioritised in a way that increases the chance of survival and a good outcome.

The categories, which set out mandatory response times across all levels of acuity are reproduced below. Delivery standards are in accordance with the NHS Ambulance Quality and Clinical Indicators, which may be updated from time to time.

Commissioners recognise that the overall achievement of response targets will be determined on a trust wide basis as per the current collaborative contract.

Categories	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 3	120 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 4	180 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

Urgent health care professional (HCP) referred cases: in addition to emergency 999 calls, ambulance services receive 999 emergency calls from HCPs, which will be prioritised and classified as per public 999 calls. Where a case is urgent (requires admission within 4 hours) but not an emergency, a health care professional may request an urgent conveyance. The ambulance service may be able to advise the HCP of alternative care or admission avoidance pathways. Where admission is required within the SWASFT contract, the ambulance service

will agree a clinically appropriate response time with the HCP of either 1, 2 or 4 hours. A national revised script of the management of HCP calls was published in March 2021.

The provision of community responders, with an appropriate governance framework, to attend emergency calls where it is difficult for an emergency ambulance to reach within effective targets, or to supplement the response to support the delivery of care.

3.5 Direct me to the right place

Directing me to the right place means that the Provider will:

- Work with local Commissioners to assist with the development of the Multi-disciplinary Clinical Assessment Service (CAS) function, to enable direct referral of patients from EOC clinicians and dispatchers to a wide range of community based services.

- Work with local partners and Commissioners to identify areas where there is a need to develop referral pathways for patients who have called 999. These may utilise or build upon existing arrangements in NHS 111. The Provider can expect a local Commissioning response that enables pathways of care that maximise the Provider's ability to manage patients in the community and ensures that unnecessary transport to hospital is minimized.

- Provide immediate access to, and utilisation of, an easily navigable electronic directory of services, shared patient records and remote decision support in a mobile format to enable referral to services following telephone and face to face assessment. It should be noted that sufficient and robust DoS maintenance procedures must be assured at local level.

The Provider will work with Commissioners and acute providers in determining pathways of care that maximise clinical outcomes for patients. On occasions, these pathways may require a patient to be transported to a regional centre – current pathways in existence, but not necessarily modelled and funded, include:

- STEMI/ PPCI
- Stroke
- Trauma
- Vascular

During 2022/23 across the region a review of the Thrombectomy pathways needs to be undertaken, including where necessary any modelling for the impact on SWASFT. The output and impact of any modelling will be discussed with each system in order for these to be recognised by SWASFT as formally commissioned pathways.

Any services that are developing revised current or future pathways must involve the Provider in the discussions and service redesign. Consideration will be given to the impact on the Provider with respect to the potential for undertaking additional or extended journeys which result from any service re-design, and discussions will need to take place with the Provider prior to any agreements being made as to how these are to be managed. Any service re-designs or centralisation which may impact on the ambulance service must be agreed by the Provider and the Lead Commissioner before implementation. Due consideration must be given to the potential impact on existing patients and the clinical and operational implications for the ambulance service and integrated UEC system as a whole.

The Provider will work with commissioners in their planning for changes in service delivery within community or acute care. Any changes to the existing infrastructure of unplanned care services and revised integrated ways of working in the locality will impact upon the Ambulance Service. For many areas this will result in a service where more patients are being seen and treated in the locality without going to a large hospital.

3.6 Any acceptance and exclusion criteria and thresholds

The Provider will provide Urgent and Emergency ambulance services to all potential patients resident in or travelling through the area of responsibility of the ambulance Provider.

The Provider Will NOT necessarily have the clinical skills required to manage all patients being transferred between healthcare establishments to an upgrade of care as an emergency or urgent case. A specialist escort(s) may be required.

In addition the following services will be provided:

3.6.1 National Framework for Inter-Facility Transfers

Emergency (high priority) hospital admissions should be managed in accordance with national guidance disseminated through the National Framework for Inter-Facility Transfers as follows.

This framework is intended for patients who require transfer by ambulance between facilities due to an increase in either their medical or nursing care need. The definition of a facility which this framework applies to are healthcare facilities that provide inpatient services. In some locally determined situations an additional “facility” will be defined by the ambulance service as suitable to use the IFT process i.e. urgent care centres with direct admitting rights to inpatient services.

Patients who have immediate life-threatening injuries or illnesses should be transferred, where necessary with an appropriate hospital escort, and within a set timeframe mapped to national performance categories defined below. Similarly, patients with serious or urgent healthcare needs should be transferred in an appropriately commissioned timeframe. Local systems should have commissioned arrangements in place for the return of personnel and equipment to facilities.

The following framework should be used so that individual systems can develop standard operating procedures and decision algorithms.

A set of inter-facility transfers levels is described with a clear definition of the patient groups that are allocated to each level. Those levels will be mapped to the current ARP categories and, where commissioned, Ambulance Trusts would be expected to respond to these requests under the same response levels as other 999 calls.

Standard Operating Procedure VH09 Inter-Hospital Transfer Requests sets out the commissioned scope and exclusions for inter-facility transfers for this contract and is included in Schedule 2J of the Particulars.

There are 4 levels of inter-facility response:

IFT Level 1 (IFT1) Category 1
This level of response should be reserved for those exceptional circumstance when a facility is unable to provide immediate life-saving clinical intervention such as resuscitation and requires the clinical assistance of the ambulance service in addition to a transporting resource. These requests should be processed through the Trusts 999 Triage tool and only those that are deemed category 1 under that assessment should receive a category 1 response. Examples would include Cardiac arrest, anaphylaxis, birth units requiring immediate assistance, or acute severe life-threatening asthma in an urgent care facility.

IFT Level 2 (IFT2) Category 2
This level of response is based on the need for further intervention and management rather than the patient's diagnosis. Immediately Life, Limb or Sight (Globe trauma) Threatening (ILT) situations which require immediate management in another facility should receive this level of response.

For instance, patient going directly to theatre for immediate neurosurgery, immediate Primary Percutaneous Coronary Intervention, Stroke Thrombolysis, immediate limb or sight saving surgery or mental health patient being actively restrained.

These IFT level 2 patients would be mapped to category 2 response under ARP. A specific set of interventions as detailed above should be strictly adhered to.

IFT Level 1 and Level 2 incidents are confirmed emergencies which require life-saving intervention and should be responded to as time critical emergencies and immediately allocated the nearest emergency ambulance.

There should be little or no variation in the proportions of the above categories across England.

IFT Level 3 (IFT3) optional to be Locally commissioned response

IFT Level 3 is only within the scope of this contract where it is specifically included in the Standard Operating Procedure VH09 Inter-Hospital Transfers. All other Level 3 transfers are excluded from this contract.

This level may be commissioned for patients who are not undergoing immediate life or limb saving interventions but require an increase in their level of clinical care as an emergency. Where this is commissioned a set timeframe for the level of response should be specified between 30 minutes and 2 hours.

This level of response may include mental health crisis transfers or those solely for the purpose of creating a critical care bed

IFT Level 4 (IFT4) Locally determined response

IFT Level 4 is only within the scope of this contract where it is specifically included in the Standard Operating Procedure VH09 Inter-Hospital Transfers. All other Level 4 transfers are excluded from this contract.

This is for all other patients who do not fit the above definitions and require urgent transport for ongoing care but do not need to be managed as an emergency transfer. Patients being transferred to inpatient wards for ongoing management or for elective and semi elective procedures or investigations. This category of patient will have a timeframe outside of the ARP standards and will be determined through their normal commissioning arrangements.

Patients who do not fit the definitions above are not appropriate for a Category 1, 2 or 3 response from the ambulance service. In some cases patients with immediately life or limb threatening conditions may not be ready for transfer within the Category 1 or 2 timeframe and require further management before being clinically suitable for transfer. In those cases a lower category will be allocated to reflect the time delay until the patient is ready for transfer.

Repatriations or step down transfers/discharges to non hospital facilities are not intended to be included in the IFT framework.

The Provider is responsible for undertaking the following types of transfers under the criteria agreed for all CCGs.

Trauma

- Patients being transferred from a Trauma Unit (TU) to a Major Trauma Centre (MTC)

3.6.2 End of Life Care patients

Palliative Care

Patients meeting all of the following criteria:

- Requires urgent (within 4 hours) transfer to or from a hospice
- Clinical condition necessitates the use of an emergency ambulance with a clinically qualified crew
- Journey is for NHS funded treatment or care commissioned by an NHS organisation.

In addition to the transfer criteria detailed above, the following criteria have been agreed for the CCG areas of NHS Bath & North East Somerset, Swindon and Wiltshire CCG, NHS Bristol, North Somerset, South Gloucestershire CCG, NHS Devon CCG, NHS Dorset CCG NHS Gloucestershire CCG, NHS Kernow CCG and NHS Somerset CCG. There is an internal SWASFT Standard Operating Procedure (SOP) which reflects the following:

Emergency Transfers

Emergency and urgent transport of patients where all of the following criteria are met:

- Patient is being transferred to a higher level of care (e.g. care which cannot normally be provided at the hospital where the patient is currently residing)
- Patient is being transferred for an intervention/treatment that requires their arrival within the next 4 hours*
- Clinical observations or interventions are required en-route.

*For the Royal Bournemouth Hospital only, this criteria also includes patients under the age of 16 who require assessment within 4 hours at a hospital with a paediatric capability.

The Provider will apply the following criteria within Gloucestershire CCG only:

Emergency and urgent transport of patients where a Paramedic crew is clinically required and the journey is within the SWASFT organisational area or specifically to Hereford County Hospital, John Radcliffe Hospital Oxford, Worcestershire Royal Hospital or Queen Elizabeth Hospital Birmingham.

Calls received from Nursing Homes, Care Homes and Domicilliary Care Providers which appear to be requesting a response purely to lift a patient who is not injured will be managed by the Clinical hub according to the Minimal Lifting in Nursing, Care Homes and by Domicilliary Care Providers (Care Agencies) Policy.

Exclusion Criteria

The service is not provided for the following:

- Non-urgent health care needs – but the Provider would be expected to fully triage such a request and signpost a person to a service that is able to meet their need.
- Calls requesting attendance to confirm the death of a resident/s within a care, residential or nursing home.
- Routine admissions to nursing, care or residential homes.
- Social transport needs e.g. attendance at outpatient/hospital appointments.
- Transfers due to internal hospital operational capacity issues e.g. Acute healthcare providers needs to move patients within or between hospital sites where this is due to an internal issue, such as a CCU or ICU having not capacity. Transport for the discharge of patients from healthcare settings.
- Inter-hospital transfers for patients from a higher to lower, or equivalent, level of care unless in line with the criteria defined above.
- Hospital discharges.

3.6.3 Mental Health patients

Mental Health

- Transport to the nearest clinically appropriate mental health facility or agreed place of safety for patients detained under the Mental Health Act (this includes section 135 and 136)
- Transport to the nearest clinically appropriate mental health facility or agreed place of safety for informal patients where a double crewed ambulance or patient support vehicle is required and the patient must arrive within the next 4 hours. This includes transfers from Emergency Departments
- Mental Health Patients being conveyed urgently to an acute hospital for immediate treatment (within 4 hours) where a double crewed ambulance or patient support vehicle is required.

Transport for mental health patients is usually agreed within 4 hours, however, to allow the principles of the mental health crisis concordat to be applied it should be noted that the timeframe can be less than 4 hours if appropriate and requested i.e. in response to section 136 transfer requests within 30 minutes. It should be noted that an emergency ambulance or Patient Support Vehicle may be utilised to undertake mental health transfers, as appropriate.

The Provider is not contracted to undertake mental health journeys which require a secure vehicle i.e. a vehicle with a level of physical security for the patient which exceeds that of a standard ambulance.

Police services across the South West have indicated they will begin to decline undertaking Section 135 or Section 136b journeys using Police vehicles. The Provider will work closely with Commissioners to reach agreement on any

additional patient volumes which occur due to this change in Police practice. South Western Ambulance Service NHS Foundation Trust will not be expected to undertake this additional activity without a formal agreement being reached between the Trust, the appropriate Police Service and CCG.

3.7 Exclusions to the Service include:

Unless stipulated within this 999 specification, all other journey types will be excluded and subject to local determination.

3.8 Clinical Quality Indicators:

Ambulance Services should report, and seek to continuously improve, clinical quality indicators as specified by NHS England. This includes performance standards such as those relating to stroke and heart attack patients. For example, see:

https://www.england.nhs.uk/wp-content/uploads/2017/07/ambulance-response-programme-letter.pdf

3.9 Interdependence with other services / providers

The Provider must be fully consulted on and will then work with local Commissioners / CCGs to respond to and support, any local reconfiguration of services.

Where alternative services have been put into place in order to reduce the need to transport Patients to Emergency Departments South Western Ambulance Service NHS Foundation Trust will access these alternatives unless exceptional circumstances prevail.

Air Ambulance Services – South Western Ambulance Service is to provide clinical staff to crew air ambulance services in accordance with Department of Health guidance and agreed SLAs with the air ambulance charities where required.

Commissioners support and agree the SWASFT position that no divert between acute providers should be agreed without the inclusion of SWASFT in the decision making process.

Local Commissioners will work proactively with the Provider and other relevant stakeholders to eliminate delays in patient handover at ED, and in accordance with standards set and monitored by NHS Improvement. The Provider will expect the impact on ambulance services to be modelled should handover times exceed the specified standards.
Reference: 20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf (england.nhs.uk)

Commissioners support the Operational Planning Guidance principle to:

* Improve against all Ambulance Response Standards, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards.
* Minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. This includes:
    - Eliminating handover delays of over 60 minutes
    - Ensuring 95% of handovers take place within 30 minutes
    - Ensuring 65% of handovers take place within 15 minutes.

Reducing the level of handover delays is the single biggest contributory factor to delivering improved response times.

Commissioners recognise that the operating environment has changed since the pandemic and specifically that the increase in hospital handover delays is materially affecting SWASFT's ability to deliver performance improvement.

The level of handover delays has increased to a point where SWASFT is unable to mitigate this impact. The consequent increases in response times and long waits in ambulances at ED are causing patient harm which is of major concern. All systems have action plans in place to reduce hospital handover delays, which Commissioners will provide assurance to SWASFT on implementation, delivery and impact.

SWASFT continues to deliver increased levels of hear and treat, and reduced levels of conveyances to ED, compared to the pre-pandemic baseline. It also maximises the operational resource within the funding available to improve patient safety and reduce the risk of harm.

The Provider engages with each ICS in the Trust area using the following principles:

- A key executive lead has been identified for each of the seven ICS areas.
- Each ICS area has a defined governance structure of which the Trust as a key provider organisation will be invited at the relevant boards / groups as appropriate;
- The Executive Lead takes an active role in the development of ICS's on behalf of the trust and the urgent and emergency care workforce it represents. This is particularly relevant to the paramedic workforce;
- During Q1 2022/23 the Trust will review its representation at CCG/ICS meetings to ensure its resource is prioritised and able to effectively engage and support the relevant ICS programmes.

A mechanism will be agreed to vary the contract in-year where necessary and agreed based on changes in activity, changes in job cycle and journey times, the requirements of the digital roadmap and any change in the location of services within the South West. Any contract variation will be agreed between the Commissioners and the Trust.

As a consequence of the uncertainty in the ICS plans the intention is therefore that the contract acts as a safeguard to the Trust which recognises the unknown

change and provides both the Trust and Commissioners with a mechanism to vary the contract in-year where necessary and agreed. Any contract variation will be agreed between the Commissioners and the Trust.

3.10 Vehicles and Equipment

Double-crewed ambulances (DCAs), should be procured in line with national requirements. The provider is required to implement the standard specification for new DCA fleet across England including a standard load list of equipment, consumables and medicines, and the inclusion of CCTV and "black box" technology. Where this presents a cost implication, the Trust will proceed with following the national specification, once funding has been agreed.

3.11 Ambulance Service Transformation

The provider is required to engage with the national transformation agenda and is committed to implementation of the recommendations of the Operational Productivity and Performance in English NHS Ambulance Trusts: Unwarranted Variations Review which requires a commitment to the delivery of a common operating model for ambulance services across England including:

- Standardised call triaging systems, process and rules.
- A best practice operating model and protocols for clinical assessment in the control centre.
- Clinical Guidance and access to community and hospital ED alternative pathways for paramedics and other registered clinicians on scene to safely reduce avoidable conveyance.
- Convergence in the technical infrastructure and common standards with shared call handling capacity and CAD interoperability across the system in the longer term.
- Development and implementation of nationally agreed disaster recovery standards for service delivery and critical infrastructure, working collaboratively with NHS oversight bodies as required.
- Ensuring the rapid testing and deployment of innovation, including the enablement of new technology.
- Implement make ready systems, where funded and appropriate, across the country.
- The provider is required to engage with the development of the Transformation Plan during 2022/23 and contribute to its implementation during 2023/2024.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE).

All Ambulance providers will adhere to NICE guidelines, and where appropriate, Joint Royal College Ambulance Committee (JRCALC) guidelines.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. the medical Royal Colleges)

4.3 Applicable local standards

Refer to Schedule 4.