



House of Commons  
Committee of Public Accounts

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# Transforming NHS ambulance services

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**Forty-sixth Report of Session 2010–12**

*Report, together with formal minutes, oral and  
written evidence*

*Ordered by the House of Commons  
to be printed 5 September 2011*

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## Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine “the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit” (Standing Order No 148).

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The following member was also a member of the committee during the parliament:

Eric Joyce (*Labour, Falkirk*)

### Powers

The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via [www.parliament.uk](http://www.parliament.uk).

### Publication

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Additional written evidence may be published on the internet only.

### Committee staff

The current staff of the Committee is Philip Aylett (Clerk), Lori Verwaerde (Senior Committee Assistant), Ian Blair and Michelle Garratty (Committee Assistants) and Alex Paterson (Media Officer).

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## Summary

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Ambulance services provide a valuable service that is held in high regard. Eleven regional ambulance services operate across England. In 2009-10, they handled 7.9 million emergency calls, and spent £1.5 billion on urgent and emergency services. Ambulance services are expected to make 4% efficiency savings year-on-year, in line with the rest of the NHS, at a time when public demand for their services continues to rise.

Until 1 April 2011, the Department measured the performance of ambulance services against three response time targets. These were introduced in 1996 to focus attention on improving basic standards and achieving consistency across the country. But the incentive to meet response time targets has led to some inefficiencies. For example, some ambulance services send more than one team to incidents, over-committing vehicles and staff. We welcome the Department's decision to introduce a wider suite of health quality indicators to create a broader performance regime in which response times remain one indicator.

There is wide variation in the cost of responding to an incident across ambulance services, which is underpinned by variation in a number of other factors, such as sickness absence, overtime and back office costs. Ambulance services need to produce more consistent performance data in order to benchmark and share best practice so that efficiency can be improved and variations reduced across the country. For example, they do not currently collect and share comparable data on the extent to which ambulance crews are utilised when on duty. Although we note the Department's and ambulance services' commitment to provide more reliable benchmarking data and reduce variation, we were disappointed that it has taken so long to address the variation in efficiency.

Under the NHS reforms, there is still a great deal of vagueness around who will be responsible for what in the new system. It is not clear who will be responsible for commissioning ambulance services, who will be responsible for improving efficiency across ambulance services, or who will intervene if a service runs into financial trouble or seriously underperforms. In the future, ambulance services will become foundation trusts and be directly accountable to Parliament, but it is not realistic for each ambulance service to be individually accountable to us for value for money. There needs to be greater clarity on the roles and responsibilities of the Department, commissioners and ambulance trusts, with appropriate structures for accountability to Parliament on value for money.

Other parts of the health system affect ambulance services' performance. A more integrated emergency care system is required to ensure that ambulances are not kept waiting outside accident and emergency, can hand over patients faster and get back out to help others. The Department has plans to align the objectives of those involved in the provision of urgent and emergency care providers. There are also varying levels of collaboration between ambulance, fire and police services which should be strengthened and we look to government to investigate the scope for further co-operation to identify

savings in areas such as procurement and back-office services.

On the basis of a report by the Comptroller and Auditor General<sup>1</sup>, we took evidence from the Department, the ambulance service and ambulance service commissioners on the value for money ambulance services provide.

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1 C&AG's Report, *Transforming NHS ambulance services*, HC (2010-12) 1086

## Conclusions and recommendations

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- 1. Ambulance services provide a valuable service that is held in high regard for the care it provides for patients, but more could be done to improve efficiency and value for money.** Wide variations exist in unit costs and efficiency across ambulance services. Better benchmarking and sharing of best practice could help to reduce these variations. Monitoring and interventions at a national level are needed to increase efficiency and achieve better outcomes and value for money. The recommendations set out below are intended to help the Department, commissioners, and ambulance services achieve these aims.
- 2. Under the NHS reforms, it is not clear who will be responsible for achieving efficiencies across ambulance services or intervening if an ambulance service runs into financial difficulties or fails to perform.** The NHS Commissioning Board will be accountable for the continuation of '999' services in all situations, but individual trusts will be accountable to Parliament. However, the Department could not clarify who will be responsible for improving efficiency across ambulance services or taking action in cases of underperformance. The Department should clarify roles and accountabilities for the emergency care system and quickly develop an intervention regime to protect '999' services in situations where providers fail.
- 3. The Department was unable to tell us who will be responsible for commissioning ambulance services under the NHS reforms.** Ambulance services are currently commissioned by primary care trusts. These trusts must commission the emergency care response to '999' calls from the ambulance service in their region, but the degree of choice in how they procure additional services, such as using paramedics in GP surgeries, is unclear. The Department must clarify how ambulance services will be commissioned and what choice commissioners will have over the providers of emergency and urgent care.
- 4. Performance information on ambulance services is not always comparable, making it difficult to benchmark services and identify the scope for efficiency improvements.** Ambulance services will have to meet demanding efficiency targets in the next few years. Although they work closely together through various forums, there is still considerable variation between ambulance services in areas such as cost per incident, the staff skills mix in ambulance crews, sickness absence and back-office costs. In addition, ambulance services do not have a standard way of measuring the use made of ambulance crews while on duty (utilisation rate). The Department should set standard definitions for the data to be measured by each ambulance service to enable benchmarking, and certify the quality of data-generating systems. Commissioners should use this data as a basis on which to seek service efficiencies. Ambulance services should use it to share best practice and maximise efficiency.
- 5. Focusing on response time targets has improved performance but has also led to some inefficiencies.** A focus on response time targets was needed to improve basic standards and achieve consistency across the country. But currently response times are measured from the moment the '999' call is received from BT, rather than after obtaining sufficient information on a patient's condition to determine the most

appropriate response. This has led to an over-commitment of vehicles and staff as ambulance services often send more than one team to an incident. This can waste resources and result in other patients not getting the most appropriate care. The Department introduced a wider range of clinical quality indicators in April 2011 and plans to review them in a year. The Department should review how response times are measured to ensure ambulance services have sufficient flexibility to identify the most appropriate response to calls before resources are deployed.

- 6. Delays in handing over patients from ambulances to hospitals lead to poor patient experience and reduced capacity in ambulance services.** Over one-fifth of patient handovers from ambulance crews to Accident and Emergency staff at hospitals take longer than the 15 minutes recommended in guidance. If ambulances are queuing in hospitals, they are not available to take other calls. Commissioners should take a consistent approach to penalising hospitals that do not adhere to the guidance of 15 minute handovers and the Department should also develop a quality indicator for hospital trusts on hospital handover times.
- 7. Ambulance services do not collaborate sufficiently with other emergency services to generate efficiency savings.** Although ambulance services collaborate with fire services and police forces in some areas, there is scope for a more systematic approach to sharing procurement and back office services across the emergency services. The Efficiency Reform Group should work with the departments responsible for fire, ambulance and police services to commission an independent review. The review should examine what efficiencies and enhanced service delivery could be achieved by increased joint-working across the emergency services and should look to maximise opportunities for co-location, for example in the empty regional fire centres.

# 1 Accountability and commissioning arrangements

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1. Ambulance services provide a valuable service that is held in high regard for the care it provides to patients.<sup>2</sup> Eleven regional ambulance services operate in England. In 2009-10, they handled 7.9 million emergency calls, and spent £1.5 billion on urgent and emergency services.<sup>3</sup> Ambulance services are expected to make 4% efficiency savings year-on-year (equating to £75 million in 2010-11), in line with the rest of the NHS, at a time when public demand for emergency health services continues to rise.<sup>4</sup>

2. Ambulance services are currently commissioned by primary care trusts. These form commissioning clusters in line with the ambulance regions.<sup>5</sup> Under the NHS reforms, clinical commissioning groups (previously called GP consortia but now requiring governing bodies with at least one nurse and one specialist doctor) will be created. They will commission most of the health services in their area.<sup>6</sup> The NHS Commissioning Board will directly commission the clinical commissioning groups as well as some other specialised services.<sup>7</sup> The Department has not confirmed whether clinical commissioning groups will commission ambulance services themselves or if the NHS Commissioning Board will.<sup>8</sup>

3. Core ambulance services will have to be commissioned in the ambulance region to which they relate. For example, ambulance services in an area in London must be provided by the London Ambulance Service, even if it is more expensive than a neighbouring ambulance service.<sup>9</sup> Due to the variation in costs of ambulance services, core services will take up a different proportion of the clinical commissioning groups' budgets.<sup>10</sup> The Department could not tell us how much choice commissioners would have over the provider of non-core services – such as having paramedics based in GP surgeries or patient transport services.<sup>11</sup>

4. Currently, the Department is accountable for the ambulance services.<sup>12</sup> Under the proposed NHS reforms, all ambulance services will be required to become foundation trusts and will be directly accountable to Parliament. We have expressed concerns in previous reports about a structure of direct accountability to Parliament for a plethora of

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2 Q 85; C&AG's Report, para 15

3 C&AG's Report, paras 1 and 4

4 Q 30; C&AG's Report, para 4

5 C&AG's Report, para 1.8

6 Department of Health, *Government Response to the NHS Future Forum report*, June 2011

7 C&AG's Report, *National Health Service Landscape Review*, HC (2010-11) 708

8 Qq 13, 18-21

9 Qq 19-20

10 Qq 39-41

11 Qq 21, 25, 123

12 Q 1

independent health trusts. This cannot ensure robust accountability in a sustainable way. The Department also told us that the NHS Commissioning Board will be accountable for the continuation of '999' services in all situations.<sup>13</sup>

5. There is a lack of clarity around who will intervene should an ambulance service fail to perform. The Department told us it would expect other ambulance services to step in to cover operations.<sup>14</sup> However, the Department has yet to finalise the failure regime to cover the eventuality of an ambulance service getting into financial difficulties. The Department told us that these arrangements will be finalised and submitted during the legislative process for the Health and Social Care Bill.<sup>15</sup>

6. We are concerned that no-one has responsibility for acting on poor performance or enforcing best practice across ambulance services.<sup>16</sup> Instead, ambulance services told us that they use peer pressure as a mechanism to drive improvements in performance.<sup>17</sup> We were told ambulance services use forums to share best practice and help deal with the inefficiencies that exist between services. We remain unconvinced this will exert enough pressure.<sup>18</sup>

7. The situation is made worse by the lack of comparable performance information to enable benchmarking.<sup>19</sup> Ambulance services do not have a standard way of measuring their use of ambulance crews while on duty (utilisation rate) so cannot compare their frontline utilisation rates against each other. Ambulance services welcomed the NAO's recommendation on the need for a standard utilisation definition and committed to produce one within three months.<sup>20</sup> Clinical quality indicators, introduced in April 2011, will also mean more benchmarking information is available. The ambulance services told us that they plan to have a website with the performance of ambulance services against the clinical quality indicators from July 2011.<sup>21</sup>

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13 Qq 2-4

14 Q 10

15 Qq 11-12

16 Qq 118-119

17 Q 122

18 Q 117

19 C&AG's Report, para 14

20 Qq 101-102; C&AG's Report, para 17

21 Qq 120-121

## 2 Improving the efficiency of ambulance services

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8. There is wide variation in the cost of responding to an incident across ambulance services. Costs per call vary across ambulance services – between £144 in the North East and £216 in Great Western.<sup>22</sup> This is underpinned by variations in a number of other factors, such as sickness absence, overtime and back office costs. The skills mix varies across the ambulance services, with some ambulance services employing more paramedics and advanced practitioners than others.<sup>23</sup> There are also variations in the back office costs of ambulance services, which have increased recently in some services compared to front line costs. The ambulance services attributed part of this to increased management support to front line staff.<sup>24</sup> Sickness absence also varies between 5% and 7.9% across the ambulance services, which is partly due to differences in the degree to which management in each ambulance service hold staff to account for their sickness. However, we note that sickness absence levels have been reducing recently.<sup>25</sup>

9. Ambulance services accepted there is room to reduce this variation and make efficiencies.<sup>26</sup> Ambulance services plan to decrease the variation in costs by introducing a ‘national tariff system’ from 2012. This will have prescribed national standards for certain treatments, but the tariffs for the standards will be set locally, so cost variations will remain to some degree.<sup>27</sup>

10. Each ambulance service has an efficiency plan to achieve savings through actions such as reduced sickness absence, changes in skills mix, headcount reductions, national procurement and lowering back office costs.<sup>28</sup> We are concerned that the efficiency savings will come from a reduction of non-core services (such as paramedics in GP surgeries), rather than making efficiencies in the core services (such as reducing sickness absence and overtime).

11. Until April 2011, there were national response time targets for category A (immediately life-threatening) and category B (serious, but not immediately life-threatening) calls.<sup>29</sup> The Department introduced them in 1996, to improve basic standards and achieve consistency across the country.<sup>30</sup> It also introduced, in April 2008, ‘call connect’ to standardise the way performance against the target was measured. From 2008, the clock for the response time

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22 Q 138; C&AG’s Report, para 2.4

23 Qq 46-47

24 Qq 75, 83-84

25 Qq 88, 104-105

26 Qq 34-35

27 Qq 29, 31-32

28 Q 34; C&AG’s Report, para 3.20

29 Q 60; C&AG’s Report, para 3

30 Q 45

targets started when the call was connected by BT. Before this, it started once key information about the patient had been obtained.<sup>31</sup>

12. The national response time targets and ‘call connect’ led to phone calls being answered faster but also meant that ambulance services often sent more than one team to incidents in order that one arrived in time to meet the target.<sup>32</sup> We heard there is wide variation across the ambulance services in the percentage of incidents where more than one response is sent (between 28% and 62% of incidents).<sup>33</sup> In April 2011, the Government decided to maintain the category targets but replaced category B with a suite of clinical quality indicators. Ambulance services told us that this will lead to a reduction in double responses being sent and give ambulance services more flexibility to find the most appropriate response for these calls, not the quickest one. Witnesses also spoke of the need to review the clock start time for responses to increase this impact.<sup>34</sup>

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31 Qq 54-55

32 Qq 43, 45, 51, 55

33 Q 49; C&AG’s Report, figure 19

34 Qq 48, 51

## 3 Collaborating with other emergency providers

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13. Ambulance services are looking to reduce the time taken to hand patients over to A&E departments in hospitals.<sup>35</sup> Over one-fifth of patient handovers take longer than the 15 minutes recommended in guidance. One ambulance service estimated that, based on the current level of delays, £4 million per year is required in additional resources due to hospital congestion.<sup>36</sup> The cost of this falls on the ambulance services, not the A&E department. We heard that ambulance services have, in conjunction with many A&E departments, set up screens which show when ambulances are due to arrive at hospital so that the hospitals can be prepared for them. Ambulance services told us that this is helping to reduce turnaround times.<sup>37</sup>

14. Currently, hospitals and ambulances have separate targets which do not incentivise cooperation. A&E Departments have their own clinical quality indicators, one of which relates to time to initial assessment of patients arriving in an emergency ambulance.<sup>38</sup> The guidance that relates to it, however, shows that the measurement clock starts only after the patient is handed over to the A&E department, or after the ambulance has already been waiting for 15 minutes.<sup>39</sup> The witnesses told us they plan to ensure that objectives across urgent and emergency care providers are better aligned.<sup>40</sup>

15. Ambulance services are looking into reducing back office costs through sharing finance functions with each other and also sharing some support functions with other areas of the NHS.<sup>41</sup> In some areas, ambulance services currently share a number of stations with the fire service and police force. These three emergency services also already carry out some joint procurement, for example, petrol and radio systems. The ambulance services admitted that more could be done and that they are currently looking into the joint procurement of uniforms.<sup>42</sup>

16. We also asked what scope there was for emergency services to work together better at the front line. The witnesses said that in their view, that joint front line services with the fire service, would lead to a second-rate service.<sup>43</sup> However, we heard of an example in Hampshire, where more coordination between the fire and ambulance services has led to a reduction in double ambulance responses being sent as the fire services are used as first responders on the scene.<sup>44</sup>

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35 Q 34

36 Q 106; C&AG's Report, para 3.29

37 Q 107

38 Q 135

39 Department of Health, *Technical Guidance for the 2011-12 Operating Framework*, January 2011

40 Qq 71, 135, 137

41 Q 85

42 Q 70

43 Q 95

44 Q 62

# Formal Minutes

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**Monday 5 September 2011**

Rt Hon Margaret Hodge, in the Chair

Mr Richard Bacon  
Mr Stephen Barclay  
Dr. Stella Creasy  
Jackie Doyle-Price  
Matthew Hancock

Mrs Anne McGuire  
Austin Mitchell  
Nick Smith  
Ian Swales  
James Wharton

Draft Report (*Transforming NHS ambulance services*) proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 16 read and agreed to.

Conclusions and recommendations 1 to 7 read and agreed to.

Summary read and agreed to.

*Resolved*, That the Report be the Forty-sixth Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for placing in the Library and Parliamentary Archives.

[Adjourned till Wednesday 7 September at 3.00pm]

## Witnesses

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**Wednesday 29 June 2011**

*Page*

**Sir David Nicholson KCB CBE**, Chief Executive of the NHS, **David Flory CBE**, Deputy NHS Chief Executive, **Peter Bradley CBE**, Chief Executive of the London Ambulance Trust and National Ambulance Director, Department of Health, and **Helen Medlock**, Deputy Director of Specialised Commissioning, South east Coast specialist commissioning

Ev 1

## List of printed written evidence

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1	NHS Confederation	Ev 19
2	Ambulance Service Network	Ev 25

# List of Reports from the Committee during the current Parliament

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The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

## Session 2010–12

First Report	Support to incapacity benefits claimants through Pathways to Work	HC 404
Second Report	Delivering Multi-Role Tanker Aircraft Capability	HC 425
Third Report	Tackling inequalities in life expectancy in areas with the worst health and deprivation	HC 470
Fourth Report	Progress with VFM savings and lessons for cost reduction programmes	HC 440
Fifth Report	Increasing Passenger Rail Capacity	HC 471
Sixth Report	Cafcass's response to increased demand for its services	HC 439
Seventh Report	Funding the development of renewable energy technologies	HC 538
Eighth Report	Customer First Programme: Delivery of Student Finance	HC 424
Ninth Report	Financing PFI projects in the credit crisis and the Treasury's response	HC 553
Tenth Report	Managing the defence budget and estate	HC 503
Eleventh Report	Community Care Grant	HC 573
Twelfth Report	Central government's use of consultants and interims	HC 610
Thirteenth Report	Department for International Development's bilateral support to primary education	HC 594
Fourteenth Report	PFI in Housing and Hospitals	HC 631
Fifteenth Report	Educating the next generation of scientists	HC 632
Sixteenth Report	Ministry of Justice Financial Management	HC 574
Seventeenth Report	The Academies Programme	HC 552
Eighteenth Report	HM Revenue and Customs' 2009-10 Accounts	HC 502
Nineteenth Report	M25 Private Finance Contract	HC 651
Twentieth Report	Ofcom: the effectiveness of converged regulation	HC 688
Twenty-First Report	The youth justice system in England and Wales: reducing offending by young people	HC 721
Twenty-second Report	Excess Votes 2009-10	HC 801
Twenty-third Report	The Major Projects Report 2010	HC 687

Twenty-fourth Report	Delivering the Cancer Reform Strategy	HC 667
Twenty-fifth Report	Reducing errors in the benefit system	HC 668
Twenty-sixth Report	Management of NHS hospital productivity	HC 741
Twenty-seventh Report	HM Revenue and Customs: Managing civil tax investigations	HC 765
Twenty-eighth Report	Accountability for Public Money	HC 740
Twenty-ninth Report	The BBC's management of its Digital Media Initiative	HC 808
Thirtieth Report	Management of the Typhoon project	HC 860
Thirty-first Report	HM Treasury: The Asset Protection Scheme	HC 785
Thirty-second Report	Maintaining financial stability of UK banks: update on the support schemes	HC 973
Thirty-third Report	National Health Service Landscape Review	HC 764
Thirty-fourth Report	Immigration: the Points Based System – Work Routes	HC 913
Thirty-fifth Report	The procurement of consumables by National Health Service acute and Foundation Trusts	HC 875
Thirty-seventh Report	Departmental Business Planning	HC 650
Thirty-eighth Report	The impact of the 2007-08 changes to public service pensions	HC 833
Thirty-ninth Report	Department for Transport: The InterCity East Coast Passenger Rail Franchise	HC 1035
Fortieth Report	Information and Communications Technology in government	HC 1050
Forty-first Report	Office of Rail Regulation: Regulating Network Rail's efficiency	HC 1036
Forty-fifth Report	The National Programme for IT in the NHS: an update on the delivery of detailed care records	HC 1070
Forty-sixth report	Transforming NHS ambulance services	HC 1353
Forty-seventh Report	Reducing costs in the Department for Work and pensions	HC 1351



# Oral evidence

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## Taken before the Committee of Public Accounts on Wednesday 29 June 2011

Members present:

Rt Hon Margaret Hodge (Chair)

Stephen Barclay  
Stella Creasy  
Chris Heaton-Harris

James Wharton  
Austin Mitchell

**Amyas Morse**, Comptroller and Auditor General, and **Michael Kell**, Director, **National Audit Office**, **Gabrielle Cohen**, Assistant Auditor General, **National Audit Office**, and **Marius Gallaher**, HM Treasury, Alternate Treasury Officer of Accounts, were in attendance.

### REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

#### Transforming NHS ambulance services (HC 1086)

#### Examination of Witnesses

*Witnesses:* **Sir David Nicholson KCB CBE**, Chief Executive of the NHS, **David Flory CBE**, Deputy NHS Chief Executive, **Peter Bradley CBE**, Chief Executive of the London Ambulance Trust and National Ambulance Director for Department of Health, **Helen Medlock**, Deputy Director of Specialised Commissioning, South East Coast specialist commissioning, gave evidence.

**Q1 Chair:** Welcome again to a regular visitor, Sir David, and welcome particularly to Peter Bradley and Helen Medlock; thank you for coming. I am going to start on this, and this is to you, really, Sir David: who is accountable for the ambulance service to Parliament, for the expenditure and for performance? Is it you, or is it your colleagues?

**Sir David Nicholson:** I am the accounting officer. In that sense, I am accountable for all of that. We do it through a series of statutory bodies, the ambulance services—who provide the service, operationally—and a commissioning system through the primary care trusts.

**Q2 Chair:** As we move towards the ambulance services gaining trust status, what happens to the accountability structure?

**Sir David Nicholson:** The accountability through the commissioning side remains the same, through the commissioning board, of which I am chief executive designate, and through the clinical commissioning groups, unless there is an alternative thought through, and I know we will discuss that later. On the providing side, the individual ambulance services will be accountable to their membership through the foundation trust mechanisms, and each individual chief ambulance officer will be an accounting officer.

**Q3 Chair:** Straight to us.

**Sir David Nicholson:** Straight to you.

**Q4 Chair:** Are you absolutely certain?

**Sir David Nicholson:** Yes.

**David Flory:** Two of the ambulance trusts became foundation trusts on 1 March this year.

**Q5 Chair:** So they will be, in the same way as foundation trusts, directly accountable to us?

**Sir David Nicholson:** Identical, yes.

**Q6 Chair:** You cannot let an ambulance trust fail, presumably, can you?

**Sir David Nicholson:** There is currently—

**Q7 Chair:** Let us go to the future, you have got 13; are we keeping with the 13 or whatever it is?

**Sir David Nicholson:** It is 11.

**Q8 Chair:** It is 11, apologies. There is no proposal to downsize that, is there?

**Sir David Nicholson:** There are no plans to reorganise those.

**Q9 Chair:** So we have 11 foundation trusts. You are confident that they can all achieve foundation trust status, are you?

**Sir David Nicholson:** We believe so, yes.

**Q10 Chair:** If one fails, what happens?

**Sir David Nicholson:** Part of the way in which the ambulance service operates at the moment is very much through mutual aid and support. They do it literally on a daily basis across the borders. They do it in relation to any emergency arrangements that are put in place, any big events, and we would expect absolutely for the service to continue, even if an individual ambulance service failed its foundation duties; we would expect other ambulance services step in in those circumstances.

**Q11 Chair:** Will that be a written-down intervention regime, or will that be a boys' club agreement?

**Sir David Nicholson:** I do not know what a boys' club agreement is. At the moment, after the pause, Ministers are considering the detail of the failure regime that will be in place for all foundation trusts.

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29 June 2011 Sir David Nicholson KCB CBE, David Flory CBE, Peter Bradley CBE and Helen Medlock

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Undoubtedly, that failure regime will set out what happens in the circumstances of an emergency service, like the ambulance service, getting into financial difficulties.

**Q12 Chair:** When? Can I ask for a time frame for that?

**Sir David Nicholson:** It has got to be done to submit as part of the Bill discussions. We can send you a note on the date and time. I have not got it with me. I do not know.

**Q13 Chair:** In the new world, where you will have GP commissioning consortia commissioning the ambulance services, how are you going to ensure value for money, efficiency and effectiveness? Let me say why I ask that question. As I read the report—I think it is a good report, from our point of view; it is a very clear report and there are a lot of data in it—what comes out is that this is an area of the world where close co-operation and integration makes real sense, both in terms of quality of service and in terms of ensuring value for money. In the new landscape, you will have 11 individual trusts. You have told me that you are going to write into the legislation, presumably, a duty to co-operate; I have some concerns that there will be fragmentation where you ought to be having co-operation. I am wondering how, in the new world, you will ensure the sort of co-operation and integration that will really get us value for money, with the GP commissioners.

**Sir David Nicholson:** Yes, you are absolutely right. We have not got to the conclusion of our discussions around how we are going to organise around that yet. There are choices ahead of us in relation to all of that. It is possible, for example, for each of the clinical commissioning groups to ask the NHS Commissioning Board to commission on their behalf, so you could actually do it nationally, if you wanted, in the circumstances that we find ourselves in, and there are some arguments for that, or you could do it through the local clinical commissioning groups and get them to organise themselves locally around, I would imagine, the current boundaries of the ambulance services, broadly like the PCTs do now, with a lead commissioner among them. They are the two options that are available to us. We have not come to a conclusion about where we go. My guess would be that we would be moving towards something that is much more similar to the current arrangements, where individual PCTs still keep their responsibilities for commissioning ambulance services, but do it collectively through the work that Helen and her team do.

**Q14 Chair:** I was just wondering, will you prescribe that?

**Sir David Nicholson:** We will, absolutely. When we have come to the conclusions, we need to talk to the pathfinders and the ambulance service about how best to do that, and then we will have a pattern across England.

**Q15 Chair:** I will bring Helen Medlock in. That sounds to me perfectly sensible, but what flows from

that, whether you do it nationally or through a coming together of consortia around the current ambulance service geographic boundaries, is that you will be top-slicing GP's budgets—consortia budgets—to fund this. I can see at best tensions, and at worst big old arguments, about how much you will demand for the ambulance service out of that. Again, it is fragmentation versus co-ordination.

**Sir David Nicholson:** Yes, and we have that exactly with the amount of money each PCT is expected to put into commissioning an individual ambulance service. You can see in the document that some are better funded than others. It is exactly the same as happens at the moment. It is perfectly possible in that environment for ambulance services to work together and co-operate, and it is perfectly possible for PCTs to do it.

**Q16 Chair:** But, again, will you prescribe that GPs will have to contribute their top slice, as determined, collectively? Will they have to contribute that towards the running of their regional ambulance service?

**Sir David Nicholson:** That is one way of doing it. The other way of doing it is just not to give it to them in the first place.

**Q17 Chair:** So this would be national; it would be NHS nationally done?

**Sir David Nicholson:** Yes, you could do either of those.

**Q18 Chair:** Have you a preference?

**Sir David Nicholson:** My preference is to build on what we have learned so far. It can work really well; I am sure we will come to it later, but the issue is, on the one hand, concentrating expertise in commissioning ambulance services, but on the other, the connection between the way the ambulance service works and the whole urgent care system. At the moment, we would rather go towards the urgent care, embedding the work of the ambulance services in the urgent care system. That would tend to move you towards a situation of more delegated commissioning than perhaps doing it once nationally.

**Q19 Stella Creasy:** Could a commissioner commission another ambulance service?

**Sir David Nicholson:** For emergencies? No.

**Q20 Stella Creasy:** Given that you have a 30% variation in the cost of paramedics, what is to stop, under this new system, the GPs saying, "Well, hang on a minute; if we have got to have an ambulance service, our service is expensive. We have got the London Ambulance Service; why don't we go for the Essex Ambulance Service?"

**Sir David Nicholson:** Not for emergency services, no.

**Q21 Stella Creasy:** This will be an area where they will have one choice, so there will not really be any variation in commissioning.

**Sir David Nicholson:** They could buy more or less, couldn't they? They could buy a different model of service if they wanted to, as they do now.

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**Q22 Chair:** How are you going to respond—these are all pretty general questions—to major incidents, anything from flu outbreaks to train crashes to terrorists? That is an area where a GP commissioning body, or even a group of consortia, are unlikely to want to spend their dosh on ensuring that we have an appropriate ambulance capacity to respond to all those three eventualities. How are you going to make sure that in the system the capability exists to have an appropriate response?

**Sir David Nicholson:** I am sure that Peter will have something to say about this, but can I just say that that is the position at the moment, of course? Individual PCTs all contribute to this anyway.

**Q23 Chair:** But you tell them to at the moment, Sir David. In the new world, they will be independent of you.

**Sir David Nicholson:** They will not be independent. They will be accountable to the NHS Commissioning Board, and the NHS Commissioning Board does have a statutory responsibility in relation to emergency planning, and co-ordinating and organising in the event of a major emergency.

**Q24 Chair:** In the new world, if M. Hodge Incorporated GP Consortium says, “I am not putting all that money into the ambulance service”, are you telling me that I have got to?

**Sir David Nicholson:** You are talking particularly about emergencies. The NHS Commissioning Board could either get them to volunteer to do it, or not give them the money in the first place.

**Peter Bradley:** The ambulance service has a statutory responsibility under the Civil Contingencies Act to be able to respond to—

**Chair:** So in a sense it is a fixed cost.

**Stella Creasy:** It is a fixed cost with no variation in it.

**Q25 Austin Mitchell:** What did you mean when you told Stella you could buy more or less? Does that mean longer response times, or stopping using the ambulance as a passenger transport service?

**Sir David Nicholson:** For example, some commissioners would like more paramedics working with general practitioners in the community.

**Austin Mitchell:** Not in ambulances?

**Sir David Nicholson:** No, not driving ambulances around, but working in the community. They are very valuable clinical staff, and they can do an enormous amount of clinical work. They could commission more of that. That is the kind of thing I was referring to.

**Q26 Austin Mitchell:** You do not mean more or less ambulances, or longer response times?

**Sir David Nicholson:** No, I wasn't referring to that, because it is a set of national standards.

**Q27 Stella Creasy:** You are going to have to break this down for us, because we are struggling with it. What will they absolutely have to pay for? What is an added extra?

**Chris Heaton-Harris:** What is the statutory responsibility that has to be provided?

**Peter Bradley:** We have said that the statutory responsibility is to be able to respond to major incidents, locally, regionally and nationally. There are national arrangements in place. There is national co-ordination and national mutual aid, and that will continue, and needs to continue. The ambulance service has a contractual responsibility to meet national response time standards for life-threatening emergencies, and that will continue. Inevitably, as has been said by Sir David, the GP consortia will have more flexibility with urgent care providers and commissioners to say, “What sorts of services in the future do we want to provide?”, particularly around those patients that do not require a visit to hospital. As we have seen from the report, the ambulance service can do much more, working with different parts of the NHS, to provide different responses to those calls.

**Q28 Chair:** Sorry, we might be labouring this a little bit. On the second point that you made in response to Stella's question, you have got to have an ambulance service that responds within eight or twenty minutes or whatever it is—the standard you have set. If it is more expensive, as it is, in the East of England than the North-East or whatever, then if I am an East of England GP consortium, have I got to pay the East of England rate?

**Peter Bradley:** Yes.

**Sir David Nicholson:** Where we want to go with the ambulance services over time, and we have already said that we will prescribe for GP consortia—sorry, for clinical commissioning groups—

**Chair:** Sorry, I got it wrong.

**Sir David Nicholson:** I'll get it right; we will prescribe their responsibilities to deliver a 24-hour, seven-days-a-week emergency service for local patients that is geographically-based. We have said that already, and we think it is important to say that. In terms of the point that you made, which I have lost in all of that—

**Q29 Chair:** It is really Stella's point. I am sitting in the East of England, which happens to be the most expensive.

**Sir David Nicholson:** Yes. What we want to do over time is go to a tariff system for ambulance services. Indeed, when we have gone for tariff systems across the country as a whole, as you will know, we start off with a variation, and over time we narrow that variation as we go towards a national tariff. I think next year we are doing the currencies, so we will set out how we are going to measure each individual bit of the ambulance service, so you will get money for see and treat, hear and treat—

**Peter Bradley:** The conveyance to alternative destinations.

**Sir David Nicholson:** Yes, so we will do that, and then the year after we will start to put money against that. Our target then is to have a national tariff system for ambulance services, so wherever you are,

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whatever mix of services you pay for, you pay the same<sup>1</sup>.

**Q30 James Wharton:** Am I right in saying that the ambulance service has a target of saving £100 million in 2010–11?

**Sir David Nicholson:** That is 2011–12. It is £75 million.

**Q31 James Wharton:** If you are driving savings now, and cost-cutting now, is there a danger that the services that you briefly referred to—the paramedics doing things in the community, and those things that are not necessarily the core services of the ambulance emergency response service—will just be cut, rather than finding efficiencies in the core service? It does appear from the NAO's Report that there is a lot of variance in the cost per call out, or cost per visit, or whatever terminology is the most appropriate to use for that core service. What can we do to ensure that we are driving efficiencies in the right place, rather than just cutting services in the easy, low-hanging fruit of this nice, in-the-community work that paramedics might do?

**Peter Bradley:** As Sir David said, the introduction of a tariff will make a difference, because then we will have greater transparency.

**Q32 James Wharton:** When is that coming in?

**Peter Bradley:** 2012.

**Q33 James Wharton:** But you want to save £100 million before it comes in—or are we only saving money once it comes in?

**Peter Bradley:** No, we have cost improvement programmes for all the ambulance services for the next four or five years.

**Q34 James Wharton:** In the intervening period, before the tariffs come in and magically solve all our problems, what are we doing to make sure that we are actually driving efficiency and not just cutting the services that are not necessarily essential?

**Peter Bradley:** The ambulance service is working hard to provide more telephone advice to patients who do not need ambulances. As the Report mentions, we are sending too many double responses to calls, so we are looking to reduce that as well, so we send a single responder. We are looking to turn around our ambulances more quickly at hospitals, which is a key part of what we need to do, because they often spend time at hospital; if we can get them moving quickly, there will be more available for calls. We are reducing our back-office costs. National procurement is another part; there are only 11 services. We are now sharing uniforms and vehicle design. There is more we can do nationally, and we have done a good job over the last few years—we have gone from 30-odd ambulance services to 11—to work nationally to see where we can reduce that variance.

**Q35 James Wharton:** If we look, in two to three years' time, at how the money was spent in the ambulance service, will we therefore see a reduction in that non-core service spend, or will those savings be found just from this core emergency response service? You can see what my concern is; it would be relatively easy to say, "We will stick with statutory duty. We don't need to drive too many efficiency savings because we can just cut this, this and this—they are non-statutory—and then we have hit our target." How are you going to ensure that does not happen?

**Peter Bradley:** Absolutely. It is a fair question, and one that we will be asking ourselves. We are absolutely committed to ensuring that we, as an ambulance service across the country, become more productive and find savings where we know that savings can be made. We have the highest patient satisfaction in the NHS; our eight-minute response time target is crucial and we will maintain it, but we recognise that large numbers of our patients do require a different response going forward.

**Q36 Chair:** How are we going to measure this? You have said that you are committed to doing it; how are we going to measure it?

**Peter Bradley:** We have just introduced, from 1 April, a new set of clinical indicators and measures, which look at patient experience and patient outcomes, and we have got 11 clinical quality indicators. That is our ability to make sure that we are providing a safe and effective service—something that we have not had in the past—and we think that will underpin everything that we are doing.

**Q37 Austin Mitchell:** One way of saving money is actually by providing more advice over the telephone. Rather than sending an ambulance, a sepulchral voice will come to me over the telephone saying, "You are malingering, you bastard! Take up your bed and walk!" and that saves an ambulance. Will it be prescribed that they have to provide some levels of service by telephone and some levels of service by ambulance? Otherwise you are going to get a patchwork quilt.

**Sir David Nicholson:** Just to go back to the other point, the other side of this is around commissioning, because the commissioners will specify the extra services that they want. If you do not provide them, you will not get paid for them, so just cutting them will not give you the benefit that you might have had otherwise.

**Q38 Stella Creasy:** Just on that point, have you done any assessment about what percentage of the commissioners' budget the core stuff will be? It is all very well saying they will do an assessment of the extra stuff they want, but if they have to pay a flat tariff for a series of emergency services, clearly that will be a different percentage of a different commissioners' budgets, won't it? Their budgets will be different, so that will affect the flexibility that they have to say, "We also want to do all the paramedics in the community stuff," and all the stuff that James was talking about as well.

<sup>1</sup> This is incorrect. There will be a 'national tariff system' with prescribed national currencies for certain treatments and conveyances, but there will be locally set tariffs for these, not national ones.

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**Sir David Nicholson:** The Report says £1.4 billion out of—

**David Flory:** £1.5 billion out of the £1.9 billion total spend in 2009–10 was on urgent and emergencies.

**Q39 Stella Creasy:** That is going to vary in different parts of the country, isn't it? The core, flat tariff will vary as a percentage of their budget that they have to pay—no negotiation, no difference in service, no commissioning. The percentage of, let us say, the Essex commissioning costs, versus the London or Surrey commissioning costs, will vary.

**Sir David Nicholson:** It will in the end be a national tariff<sup>2</sup>.

**Q40 Stella Creasy:** For the commissioner, as a percentage of their budget, it will be a different percentage, won't it?

**Sir David Nicholson:** Well, it depends on how much they use the service. It will be driven by utilisation of service. If they use the service a lot, it will be a bigger proportion.

**Q41 Stella Creasy:** That is going to create a pressure not to use the service so that it is not so great a percentage of their costs.

**Sir David Nicholson:** That is the same with any health care delivery, whether it is emergency services or elective; the more they use, the more it costs.

**Q42 Stella Creasy:** Can you see the pressure? It goes on from the point that James was making. How do we know that we are not going to see the low-hanging fruit go, or more voices saying, "Look, don't get in the ambulance. We haven't got the money for it"? I don't doubt the ambulance service; I am talking about what the commissioners will do. That is beyond Peter's control, isn't it?

**Sir David Nicholson:** It is then the commissioner's responsibility to ensure that they commission services that meet the needs of their population. That is what they are there to do.

**Q43 Stella Creasy:** But what if the voice says, "You don't need an ambulance" and Austin says, "I do"?

**Sir David Nicholson:** On that particular issue, there is no doubt that there is a variation across the country at the moment about how that is used. We are implementing at the moment a systematic way, based on clinical advice, of being able to get information from patients that identifies whether they are suitable for hear and treat—the NHS Pathways system. Is that right?

**Peter Bradley:** Yes, I think it is fair to say that up until 1 April this year, the ambulance service had to send an ambulance to 70% of its calls because of the way the targets worked, and quite a few of those patients really did not need an ambulance, quite frankly. Since we have brought the new clinical indicators in, and removed one of the time targets, the ambulance service has more discretion to provide a different service.

**Q44 Chris Heaton-Harris:** For the pure politician in me, can you just re-emphasise that point—that the targets were driving an obscene outcome where we were sending ambulances with paramedics to one place, knowing full well possibly that there might be an accident and they might be needed elsewhere?

**Peter Bradley:** I can reassure you that the ambulance service and the Department of Health wanted more flexibility about how we responded; we have now got that.

**Q45 Chair:** Just to get a bit of balance here, if you are going to start being political: the Report also says on page 22, paragraph 2.2, that in London, 95% of calls have been picked up in five seconds, since you had the target, as against five years ago, when it was 40%. It also says that cardiac survival rate in London improved from 15% in 2008–09 to 22% in 2009–10, and that part of that was due to the target. So there is a balance, and one of my points is: don't throw the baby out with the bathwater. There has undoubtedly been an improvement in patient outcome, which you want to sustain in your new outcome, as opposed to target—I don't really understand the difference—regime.

**Sir David Nicholson:** Our experience of targets is exactly as you say. They are very powerful when you are a long way back from where you want to be, but they are a blunt instrument. In a sense, we have got over that. The eight-minute rule actually started in 1996, so the previous-but-one Government implemented that.

**Q46 Austin Mitchell:** Targets do not tell you anything about outcomes. In terms of paramedics and ambulances, which one assumes must be a good thing, some trusts have them and others do not; some trusts use them on a bigger scale than others. While it seems, on the prima facie case, beneficial, you cannot prove, unless you have got the research on outcomes, whether the presence of a paramedic actually produced better outcomes, can you?

**Peter Bradley:** I think that is fair. Every ambulance service in England has paramedics.

**Q47 Austin Mitchell:** But not on the same scale.

**Peter Bradley:** Not on the same scale. The Report identifies quite a variation. However, it is fair to say that that variation is narrowing significantly, and I believe that within 24 months, every fast response car that attends a life-threatening call in England will have a paramedic on it. With the new clinical outcome measures, we will have had experience by then to be able to assess the outcome of that and evidence improvements.

**Q48 Stephen Barclay:** Can I just come back to something that you said to Mr Wharton a moment ago, which was that one of the efficiencies you are looking to put in place is to reduce the number of cases where two ambulances are sent to the same place? You said, I think, if I heard correctly, that you are now putting in place measures to reduce that; was that the case?

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<sup>2</sup> It will in the end be a national tariff system, with national currencies and locally determined tariffs

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**Peter Bradley:** That is what we are trying to do, and the National Audit Office recommends that we relook at where the clock starts in relation to the eight-minute target, as we speak. The Department of Health, the ambulance services and the commissioners are keen to review that.

**Q49 Stephen Barclay:** I just want to understand the variation in performance. You are the chief executive of the London service, and you have been for 10 years. The second worst was London; in 61% of incidents, more than one vehicle was sent—this is on page 33 of the Report. So the area you are looking after is the second worst for sending double allocation. In the East Midlands, it is 28%, which is quite a stark difference. I was also quite struck by South Central, who clearly were sending a large number of vehicles, and then put in place a change. The response ratio in Hampshire reduced from 1.3 to 1.15, so why were you not able to do what you are doing now at an earlier date?

**Sir David Nicholson:** I will try this, and you can tell me if I am wrong. The issue here is that neither end of that figure—the percentage incidence—is right. Just because they have sent a small number does not mean that they are providing a really good service. The reason for that is to do with when the clock starts.

**Q50 Stephen Barclay:** Sir David, that wasn't my question. You are answering a different question. We had an exchange previously, where I said that there could be very good reasons for variation in areas. In my question, I said that London is very much in the upper tier, and you have been in place for 10 years. We hear a lot in this Committee about the fact that improvements are about to be made; it is a recurring theme in evidence that we get. We are in a fortunate position, in that you have been in place for 10 years, running this service; you are now putting in place an improvement plan. I am trying to understand, from lessons learned, why that plan did not go in place five, six or seven years ago.

**Peter Bradley:** There are two parts to the question. The reason why London has the highest level of double-dispatching to life-threatening calls—the Report doesn't make that clear; it is to life-threatening calls only<sup>3</sup>—is that we have a large number of resources in a small geography, and we do not rely at all on volunteers to respond to those calls. It is purely full-time staff in a small, built-up area. So, often we will have calls on the Underground; we have two resources and we send two resources.

**Q51 Stephen Barclay:** The geography is not changing. What I am trying to understand is that you are able to put in place something now, but you were not able to do it five years ago. What is it that has changed from five years ago?

**Peter Bradley:** The target has changed from 1 April 2011 and we now no longer, as I said earlier, have to send ambulances to a third of our calls, and therefore

we have greater flexibility to hold on to vehicles to find a more appropriate response for those patients, which means that we can reduce, to a certain degree, the double dispatching. Having said that, we will need to make a further change, in our view, to the clock start time to get the double dispatch to a level that we are happy with.

**Q52 Stephen Barclay:** What is it going to be? I can understand that one of the targets has changed, and that gives you a degree of flexibility, but there are other targets still in place, so that flexibility is limited.

**Peter Bradley:** Yes.

**Stephen Barclay:** If we look at this in 12 months' time or in two years' time, in your estimation, given the limits you set out at the start about the geography and other criteria, such as the Underground, what is it going to go to?

**Peter Bradley:** In 24 months' time—we are working with our commissioners on this—our aim is to get it down to 1.4.

**Q53 Stephen Barclay:** Which is what, as a percentage?

**Peter Bradley:** Rather than 60% of our life-threatening calls getting two resources, 40% of calls getting two resources.

**Q54 Chair:** Stephen, I just want to come in because I do not understand. I want you to explain "Where the clock starts." What does that mean? What has changed?

**Sir David Nicholson:** What used to happen was that every ambulance service started the clock on the eight minutes at a difference time, so some of them started it when the phone went; some of them started when the ambulance was on the road. In 2007–08, we brought in a single way of doing it.

**Q55 Chair:** When is it?

**Sir David Nicholson:** The clock starts when they answer the phone.

**Peter Bradley:** No, it starts when BT gives the call to the ambulance service.

**Sir David Nicholson:** Yes, when BT gives the call to the ambulance service; sorry, it is not when BT answers the phone; it is when the call is transferred to the ambulance service. As soon as the ambulance service gets the call, the clock starts. So if you send two ambulances or three ambulances, at that time you do not know the seriousness of it. You only get to know as more information comes over the phone how serious it is, so you can make a judgment about whether the people that you are sending are the right people or not. What happens in the those circumstances is that by the time you have got all the detail, which may be three or four minutes later, you may have three ambulances on the road going. The issue for us is whether we start the clock a bit later when they have got more information about an individual person. So, in resource terms it would be better, because then you would know what you can send. The danger with that, of course, is that it may impact on the number of patients we save.

<sup>3</sup> Data presented in paragraph 3.10 and Figure 19 of the NAO report shows incidents where more than one vehicles was allocated for all emergency incidents, not just life-threatening ones.

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**Q56 Stephen Barclay:** When did that change get made?

**Sir David Nicholson:** We haven't made that change.

**Q57 Stephen Barclay:** So we are still operating with people starting the clocks at different points?

**Sir David Nicholson:** No.

**David Flory:** The call-connect clock start system that David has just described started on 1 April 2008.

**Q58 Chair:** This is really interesting. What are you saying? The stats that I read out in response to Chris saying, "Oh, the target is wrong" demonstrated that the fact that you were meeting the time limit is saving lives.

**Sir David Nicholson:** Yes, it is.

**Q59 Chair:** Are you now telling us that you are looking at whether some lives can be lost to save money?

**Sir David Nicholson:** No, because the other side of it is that you may not get the right people whom you need to the patient. What you have to look at is whether, first of all, shifting the clock time to when you have got more information will actually enable you to get the right people to the right person at the right time, and, secondly, whether you could use resources better. We are looking at that but we haven't done anything about it.

**Q60 Chair:** The other thing that came out in your answer to Stephen was that you said that you were doing a third fewer—

**Peter Bradley:** I said we had the discretion over a third more calls now.

**Chair:** Explain that to us. What has changed to make that the case?

**Peter Bradley:** Up until 1 April 2011, we had to send an ambulance to all category A calls, which is 35% of our calls, and all category B calls that we had back then, for which we had a 19-minute response.

**Q61 Stephen Barclay:** South Central had to play by those rules as well, didn't they?

**Peter Bradley:** Yes.

**Q62 Stephen Barclay:** The point is that you are using an argument that says that you are at a high level because you were constrained by these targets. What I am saying is that other areas were constrained by these targets and got their numbers down. What I am trying to get clarity on is why, if you have been in post for 10 years, you did not get your act together in the way that they did. What is the reason for that?

**Peter Bradley:** Let me answer the South Central/Hampshire issue first. Hampshire has the highest level of volunteers in England by a long way. They routinely send fire-fighters as first responders, co-responders, to calls. They are heavily reliant, rightly and effectively, on those volunteers. The London Ambulance Service has been unable to get an agreement to use fire-fighters in London because of a range of issues and it is pretty rare, in any case—for an urban service at least—to use fire-fighters to provide a first response. But in rural Hampshire, it has

been very effective. That is the reason why they only send one response.

**Q63 Stephen Barclay:** Is that because they are using retained firefighters?

**Peter Bradley:** Yes, correct.

**Q64 Stephen Barclay:** So the retained fire-fighters are willing to act as paramedics.

**Peter Bradley:** Not paramedics.

**Q65 Stephen Barclay:** Let me rephrase that, because it goes to the heart of a discussion that I am having with my local fire service, and it is interesting that retained fire-fighters have never gone on strike, but that is a separate side-issue. Retained fire-fighters, where it is a pay-as-you-go service and you only pay for what you use, are willing to support the ambulance service, in a way that full-time fire-fighters in London have refused to?

**Peter Bradley:** I would not say that in London they have refused.

**Q66 Stephen Barclay:** Are they doing it?

**Peter Bradley:** No, they are not, but recently we have just trained large number of London fire-fighters and we have defibrillators on every fire engine in London. They are able to assist us at calls, which is a fantastic move forward and has only happened in the last few months. No urban ambulance service in England has fire-fighters responding to calls.

**Q67 Stephen Barclay:** When did you as chief executive first ask them to make that change?

**Peter Bradley:** The one I have just outlined? I didn't ask. It was a jointly agreed thing; we had been talking about it for some time.

**Q68 Stephen Barclay:** How long? You have been in post for 10 years; how long did it take you to suggest that this might be an improvement with the fire service?

**Peter Bradley:** There has been a joint discussion for a number of years.

**Q69 Stephen Barclay:** Can I have an answer, please? You must have an idea of how long you have been in discussion with the fire service.

**Peter Bradley:** The first time I floated the idea of fire-fighters in London responding to calls alongside the ambulance service was when I was operations director at LAS in 1996.

**Stephen Barclay:** Since 1996? And it is only just now that there is agreement?

**Chair:** But there is a more general question, Stephen, arising out of this.

**Stephen Barclay:** There is a value-for-money issue.

**Q70 Chair:** Absolutely; this might be a question for you, Mr Bradley. Why are we not—at least with the back-office function, and probably up the chain a little bit—combining all the emergency services? This is clearly happening on a voluntary basis in Hampshire, but it would be all the 999 services: police, fire and ambulances. Why are we not doing it? What is the

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inhibitor to bringing those three services together to work closely, particularly around back-office functions? If there is not an inhibitor, why are you not doing it? Would it save you money?

**Peter Bradley:** It could save us money. I would also like to make the point that the ambulance services are the professionals that respond to the patients in life-threatening conditions; we do not have police going to them. Each emergency service in England has got its specialist function and we cannot take that away.

**Chair:** I understand that.

**Peter Bradley:** As for back-office functions, I could not agree more. We need to do more. We are now sharing stations with the fire service; we share stations with the police force; we are in discussions about joint uniform procurement across England as well, and there is petrol, too; and we have got a radio system now that is in place all across England. So we have made some good strides, but there is more to do. Personally, I think the ambulance service—I would say this, wouldn't I?—has led the way. We have gone from 30-odd ambulance services down to 11. We work very quickly and effectively together, and we have proven that on a number of occasions.

**Q71 Chair:** What is inhibiting further co-ordination, co-operation and integration?

**Peter Bradley:** There are no real inhibitors. The ambulance service needs to prove to itself that it can make the improvements.

**Chair:** Can Helen Medlock just answer that, because she has been desperate to get in?

**Helen Medlock:** I just want to follow up on that. It comes round to one of the earliest points that you made around the co-operation among ambulance services across the country and co-operation across emergency services. What the NAO Report is saying and what we are really trying to achieve is co-operation across urgent care services in the health service; 90% of the calls that ambulance services go to are patients with an urgent care need, who need the right bit of care within their community, either at home or through out-of-hours GP services or in hospital, but it is urgent care. This is where we need the greater co-operation, to make sure that we have got those pathways working. That is what we are trying to commission, and the NAO Report very much highlighted that.

**Q72 Chair:** In my simple mind, the times you see all three services appear at an incident is a lot; do you need it? I have never dialled 999, but as I understand it, you go through to 999 and then they say, "Which service do you want?" This is another area where a simple brain says, "Hang on a minute, that is two lots of people involved in responding."

**Helen Medlock:** I would say that those types of incident that are public, that are out in the street, where you have a road traffic incident, are one issue, but the majority of calls are patients at home who need an urgent care service. We are looking at two different extremes.

**Q73 Stephen Barclay:** Let me follow the Chair's line, which I think is very interesting in terms of management and back-office costs, because the Report says that staff costs have gone up by 15% over the last four years, against an NHS average of 9%, while at the same time productivity has fallen. Can you just tell us what has happened to management costs over the last four years? To what extent have they gone up or down? If it is easier, let's do it for London. What are London's management costs this year, compared to four years ago?

**Peter Bradley:** Management costs are higher in London than they were four years ago, but then we have recruited an extra 500 staff in the past five years.

**Q74 Stephen Barclay:** In back-office functions?

**Peter Bradley:** No, 500 front-line ambulance staff. Therefore we have had to increase the management cover to provide support and supervision for staff.

**Q75 Stephen Barclay:** All I am asking about is the back office. I will take a figure from the East of England, and you may, because you have a national remit, be able to explain. I am sure that there is a very good reason for it. These are bright people managing big budgets, but management costs, just having a quick look at their accounts this morning, have gone up from, in 2008–09, £14.3 million to £17.78 million. That is a 23% increase in management costs in 12 months. They do not give any further detail in their annual accounts and when I phoned them this morning to ask them for a breakdown they said that I need to submit an FOI request, which I find a little disappointing. Do you have a sense of why they would have gone up by 23%? What has happened with yours?

**Peter Bradley:** Our management costs have gone up. The East of England has the highest management costs in England; that is a fact. The London Ambulance Service has the second highest management costs in England, as a proportion. They are too high. Both the London Ambulance Service chief executive, which would be myself, and the chief executive of the East of England Ambulance Service, having met in the past three months as a team nationally, recognise the fact that we need to reduce our management costs.

**Q76 Stephen Barclay:** But you have been in post for 10 years. I appreciate your candour in saying that they are too high—and perhaps we will come on to the accounting officer who is responsible for paying those cheques—but why are they too high, if you have been in post for 10 years?

**Peter Bradley:** As the service grows, management grows. Also, as a service grows, you look at providing more support for staff out in the field as they change their role. One point I would qualify in the Report, which, as you say, goes into a huge amount of detail, is that I would say that there is some disagreement about what is classed as a manager and what is classed as a clinical supervisor providing patient care. I would say that for London some of the figures classed as management are actually clinical support out in the field, providing front-line care.

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**Q77 Stephen Barclay:** Sure. Looking at definitions, we had consultants and contractors and the confusion between the two, so reclassifying things is an issue. What are your management costs for London? You said they were the second highest. What were they in 2008–09, and what are they for 2009–10? What is the difference between the two of them?

**Peter Bradley:** I would have to come back to you with the exact numbers.

**Stephen Barclay:** Yes, could you let us have a note, and give us a detailed line-by-line breakdown of what those are?

**Peter Bradley:** Yes.

**Q78 Stephen Barclay:** I am slightly pinching my colleague's thunder on this, but I hope he does not mind, because it ties in with this point. How many people do you have in your Media and Communications department in London?

**Peter Bradley:** 12.

**Q79 Stephen Barclay:** You have 12. Full-time people?

**Peter Bradley:** Yes.

**Q80 Stephen Barclay:** And how much does that cost?

**Peter Bradley:** I could only give you an approximation. If you want the exact number, I will need to get back to you.

**Q81 Stephen Barclay:** Could you let us have a note with their roles and responsibilities and their cost? Could you give us the approximation, please?

**Peter Bradley:** I would estimate the cost of running that department at around £500,000 a year.

**Q82 Stephen Barclay:** And would you define that as a front-line service?

**Peter Bradley:** It is front-line support; it is not a front-line service, in terms of providing patient care, but clearly with the 7/7 inquest that we have just had, there has been a huge requirement to support our staff in that, and they provide a valuable service.

**Q83 James Wharton:** Very briefly, just coming in on that point and going even further to steal my colleague's thunder, figure 10 shows staff numbers from 2007 to 2010 in three—I accept they are very broad—bands of types of staff: “qualified ambulance staff”, “support to ambulance staff” and “other”. A rough calculation indicates to me that between 2007 and 2010, “qualified ambulance staff” has gone up by 7%; “other” has gone up by 5% but “support to ambulance staff” has gone up by nearly 33%, which would appear to be the great bulk of the increase in staff numbers in the service. Who are these people and what do they do?

**Peter Bradley:** There is a range of people under that description. It includes obviously IT, communications, HR, and finance.

**Helen Medlock:** Control centre.

**Peter Bradley:** Control centre staff, who answer the 999 calls, and vehicle workshop repair staff, cleaners and a range of support staff.

**Q84 James Wharton:** Why is it that you now need more support staff per front-line ambulance personnel than you did four years ago? There has been a significant increase in the number of support staff per front-line person delivering a service; why is that?

**Peter Bradley:** One of the big criticisms of the ambulance service from its staff, in the staff surveys going back, was that they never saw their management; there were no managers. Ambulance staff, by and large, work unsupervised. Increasingly, they are out for their whole shift and they do not see management. I am not here to defend the number of managers that we should or should not have; we can all do more to ensure that management costs are managed carefully. What I can say is that—and I have been in the ambulance service for 30 years, and I know ambulance service staff very well indeed—their criticism often is that they do not have 24-hour management support. What we have tried to do across England is improve staff support outside hours. You have seen some of the issues our staff face, and they have been poorly supported in the past with front-line support outside office hours. We are very good at providing office-hour support, but not outside hours. So I believe that an increase in operational and clinical support management has long been overdue and needed in the ambulance service. They were under-supported in the early 2000s.

**Q85 Chris Heaton-Harris:** First, it sounds like we are all having a go at you, but can I just say that all of us appreciate the job that the ambulance service does? I have noticed—I have actually followed the politics of the ambulance service for a period of time—the quite dramatic improvements that have come through the service. I am sure my constituents appreciate it as well. So we are not being bean-counters, but we are trying to get where the value for money is. There are some interesting issues that are drawn out in this Report. I am in the East Midlands, and the East Midlands Ambulance Service has a fantastic communications team—I know that because they communicate with me regularly. I cannot find out from an annual report how many of them there are, but I have managed to find out their responsibilities now, and there seems to be an opaque nature about the back office of the ambulance service. How is that going to improve in the years to come?

**Peter Bradley:** In terms of making it more transparent or reducing it?

**Chris Heaton-Harris:** Well, both, actually.

**Peter Bradley:** We are having to look very seriously at what we do. We are looking at sharing finance functions across the ambulance service; as Helen has mentioned, we are looking at sharing with other parts of the NHS some of our support functions—one ambulance service is looking at outsourcing its whole finance function to get better value. There is much more we can do and that we are going to have to do. Clinical audit and research is an area where the ambulance service has struggled in the past, and we need to look at sharing more of our resources together nationally. I have got pretty good information on this; as 11 ambulance services, we worked extraordinarily hard to get there to provide mutual support and

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transparency. I am disappointed if you cannot get the information that you want, and we can certainly make this available to you.

**Q86 Chris Heaton-Harris:** Yes, I was going to ask Sir David; I do not know whether you had an itch or whether you were putting your head in your hands when Mr Barclay was talking about the quality of the information in the annual report for the East of England.

**Sir David Nicholson:** It was disappointing that an MP would have to go through an FOI to get information.

**Q87 Chris Heaton-Harris:** I'm going to be in the same boat for the East Midlands.

**Sir David Nicholson:** That is not acceptable.

**Chris Heaton-Harris:** I just think that something from the accounting officer could be suggested.

**Sir David Nicholson:** Fine, yes.

**Q88 Chris Heaton-Harris:** Because then that allows us to do our job in a much more efficient way and not upset people by asking for information that should be there, and would be there in most other reports. I have a couple of other questions, if I may. Again, I do not want to seem harsh on the ambulance service, but the ambulance service does seem to have the highest level of sickness within the NHS by quite some way, and the number of days lost on average, I think, is 5.2%, 18.9 days. That is the best part of four working weeks. That is a lot. Firstly, I would like to know how that breaks down between qualified ambulance staff, support to ambulance staff, and other staff. Where is the pressure point in that? I also assume in my mind that a lot of this would be the qualified ambulance staff under the stress of some of the stuff they have had to deal with; how are you helping those people through that process, and indeed achieving efficiencies by doing so?

**Peter Bradley:** There is much more we can do. I am a paramedic by background. I know that ambulance staff have a very stressful job. Our staff satisfaction levels are low; they are the lowest in the NHS. There is a whole range of reasons for that. Partly it is about being out on the streets 12 hours a day providing care, and I have mentioned before about the management support for that. Sickness has reduced for the last nine months, down to 5.6% from 7.2%, so working nationally with each other, the 11 Ambulance Service HR directors have been trying to think of ways to improve sickness management. I do not have the figures—if I did have the figures, I would share them, obviously—but I think the ambulance service probably has the lowest sickness levels of the three emergency services. In my view, that is a better benchmark than against other parts of the NHS.

The Boorman Report talks about how we can provide better support for our staff, engaging with our staff. A lot of our sickness is musculoskeletal and back injuries, and we have increasingly provided better health and safety training: tail lifts is one example, and hydraulic stretchers. We are seeing, slowly but surely, the number of injuries relating to back and musculoskeletal problems reducing. The worrying one for me is stress levels, stress-related illness; that

remains high. In my own ambulance service, we have 120 staff trained, who are there to listen; they are called LINC workers, listening, supporting and communicating with staff. They provide peer support. One thing we have seen is that, because the ambulance service is very busy, they spend little time on station, and a big part of the ambulance service de-stressing is actually talking to their colleagues at the ambulance stations. It is quite right that they are out providing a service; they aren't there to sit at the station watching TV. Nonetheless, one of the unintended consequences of having them out and available has been that they do not have the time on the station to sit down and de-stress.

**Q89 Chair:** Can I ask you for a statistic? What percentage of the time does an ambulance worker spend out?

**Peter Bradley:** It depends which service you are talking about. In the London Ambulance Service, they spend all 12 hours out on the ambulance.

**Q90 Chair:** But they may be on the ambulance in the station?

**Peter Bradley CBE:** No, out. Off the station.

**Q91 Chair:** The reason I ask is that I know in the fire service only 9% of their time is actually—maybe I have asked the question in the wrong way—spent fighting fires. On the ambulance service, what percentage of their 35-hour week is not on call, but out?

**Peter Bradley:** The England figure is 52% utilisation, and the London Ambulance Service last month was 81%.

**Q92 Chair:** And how has that changed over time? It is still not brilliant.

**Peter Bradley:** We believe to provide a safe service it needs to be nearer 50%.

**Q93 Chair:** Why?

**Peter Bradley:** I am not an expert or a mathematician, but it is to do with queuing theory and the ability to have resources available. One of the big improvements that we have had, crucially, is the change to the target on 1 April, because now we do not have to send ambulances to those calls that do not need an ambulance.

**Q94 Chair:** That will mean that they will be in house more often.

**Peter Bradley:** It will bring down our utilisation and mean that we can provide a more flexible response to our patients. That's a good thing.

**Q95 Stephen Barclay:** It is startling, isn't it, that you have got your crews potentially working 81% of the time, while down the road there are fire crews who, if they were in Paris, would be helping—in Paris, they twin-hat—but who, here, are out only 9% of the time? There seems a huge disparity in the amount of calls on ambulance crews at 81%, and fire crews at 9%.

**Peter Bradley:** I cannot comment on the whys and wherefores of the fire service, but what I can say from

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my visits to the US and Canada is that when the ambulance service works very, very closely with the fire service—as they have merged—it becomes a very, very poor, second-rate service. That is quite a sweeping statement, but the professional service we provide is to provide clinical, advanced life support and care.

**Q96 Stephen Barclay:** You can keep it distinct.

**Peter Bradley:** You can, and that is why I think Hampshire does a good job, because they have got the best of both worlds: a co-responder, but they are not substituting the ambulance service. The concern in London, to give you one example, is that it would become a substitute: “We will send a fire engine, so no more ambulances are needed now.” The co-responder model is a good one because you get the initial response to provide the basic life support, and you get the ambulance following.

**Q97 Amyas Morse:** Just contributing to this picture, are there institutionalised levels of overtime? As we look at this scene of sickness, pressure and then what is described as relief work, which are at very high and structurally maintained levels, that is part of an equation, isn't it? These things are not separate. They make up an overall picture of how the resource is working. If I am an ambulance driver, is it normal to expect to have overtime as part of my routine arrangements, so that it is part of my basic package?

**Peter Bradley:** In a number of services for the past few years, it has been seen that way. That has been for a number of reasons. Overtime over the last 12 months has dropped by 8% and will drop even further this year. The ambulance service needs overtime to give flexibility, and a great case in point is the weekend just passed. We have had Wimbledon; we have had a heat wave; we have had the busiest life-threatening call day in London in its history, and therefore you need to have that flexibility to be able to bring those resources in. Nonetheless, we recognise that we want to bring that overtime down and will see it drop further over the next two or three years.

**Q98 Amyas Morse:** So we should look for a resting model of overtime to get to a level where it is a surge capacity, rather than normally used?

**Peter Bradley:** Yes.

**Q99 Amyas Morse:** In a reasonably short time?

**Peter Bradley:** I would think within the next 24 months.

**Q100 Stella Creasy:** On that point, London is also facing a substantial reduction in the number of staff working in the London Ambulance Service, and one of the ways you say you will save money is through reducing the number of agency workers. If you need to have the flexibility because you are coping with major incidents like heat waves and the Olympics, isn't cutting paid staff short-sighted, because you are going to end up paying money for agency workers to make up the difference if you have another heat wave? We cannot predict that there is not going to be another heat wave, and the Olympics is going to be an added

pressure; is that not rather the wrong way round to look at it?

**Peter Bradley:** There are two parts to that: the agency staff are not front-line staff. The agency cost reduction in the London Ambulance Service relates to agency in back office. We do not have them in the front-line. All the ambulance staff are full-time, paid ambulance staff.

**Q101 Chair:** I just wanted to ask Michael Kell a question; is 50% utilisation considered good, bad, indifferent, or what?

**Michael Kell:** As Peter said, it will depend a lot upon how the services decided to configure it. One of the problems that we identified was that different trusts measure utilisation in different ways, which makes it hard for anybody to see whether the way one service is utilising their staff and resources is better than another's. It is complicated to say in the best circumstance, and it is made worse because of this lack of comparable data.

**Q102 Chair:** Are you measuring in such a way that we can do comparisons across the country?

**Peter Bradley:** We will be. The NAO Report makes a good recommendation and we will be doing that.

**Chair:** From?

**Peter Bradley:** Within the next three months.

**Q103 Chris Heaton-Harris:** Just coming back to the breakdown of staff sickness figures, would it be possible, in the note that you are going to send, to give us a breakdown of where the sickness lies, by staff group, to match up with figure 10?

**Peter Bradley:** Absolutely.

**Stephen Barclay:** And overtime by staff group? It strikes me that if you have got institutionalised overtime, and overtime is part of the role, then potentially that is one of the contributing factors to sickness, because if people are working overtime as a matter of course, then potentially this is going to increase sickness rates, but then, also, from a value-for-money point of view, it does not really make sense to be paying overtime for people to cover for poor sickness rates.

**Q104 Austin Mitchell:** It was mentioned in answer to Chris, on stress levels, that it was low in London. I see from the table on page 32, when it comes to ambulance service and NHS sickness absence, sickness absences among ambulance staff is highest in the North-East, 7.9%, and pretty low in London, 5%. I would have thought the job was more stressful in London. I would frankly hate to drive in London, whereas driving in the North-East is a pleasure, apart from other drivers.

**Peter Bradley:** Fair point. North-East absence levels have reduced.

**Q105 Austin Mitchell:** Why do the levels vary so much?

**Peter Bradley:** It is partly around how it is being managed, to be honest, and I think that the human resources directors for England would say that most of the absence is short-term absence. It is about the

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ability of the management to hold staff to account for why they have been off for short-term absence. Short-term absence is an issue in the ambulance service. In London, for this particular year, we were very good—not at everything, as has been said already, but at this. We were good at making sure we followed up on every staff member who went off sick, either through an individualised, personalised phone call or a meeting with them. But North-East has dropped, and the gap between the lowest and the highest is quite small now.

**Q106 Austin Mitchell:** Following up on what Chris said, I am happy with the ambulance service we get in Grimsby, apart from the fact that you never know where it is coming from—whether from Humberside or Lincolnshire. Is it coming from Yorkshire, as it is now? You never know. We are trundled around like a piece on a chess board, but I was interested in 3.29 on page 40, which is about hospital congestion, because the time for handover, between ambulance and hospital, varies between 20 and 35 minutes, and the data for 2010–11 suggest that at least one fifth of emergency transport to hospital results in a patient handover that takes more than the expected time of 15 minutes. There was an estimate there that by avoiding queues and delays at hospitals—I know we have all seen something of that—£4 million a year could be saved, because that is the cost of additional resources due to hospital congestion. Why does it vary so much?

**Peter Bradley:** It is partly linked to how busy the hospital is.

**Q107 Austin Mitchell:** The costs to the service fall on you. It is the hospital's responsibility, but you carry the can.

**Peter Bradley:** Yes. I am probably stating the obvious, but most of it is around the ability of the ambulance service when they arrive in A and E to be able to do the clinical handover with the triage nurse. Are they available, there and then, when the ambulance arrives? What has been happening in recent times is big screens going into A and E departments across England, which show, with direct access to the computer system in the ambulance control room, when the ambulance is coming in. "A patient with chest pain is arriving in 10 minutes. A patient with a broken ankle is arriving in half an hour." This is helping them increasingly; there is more work to do, to be able to plan the arrival of the ambulance and work with the ambulance staff.

**Chair:** I have seen that in practice.

**Q108 Austin Mitchell:** Where does that occur? A lot of the computer systems do not coalesce.

**Peter Bradley:** It is not part of a national IT system; it is a stand-alone system and ambulance services are doing it now themselves with hospitals.

**Q109 Chair:** One of the issues, if you look right at the beginning of the report at figure 3, is your call volumes—they have basically doubled in a decade. They are increasing. This is a question to you, probably, Sir David. Ironically, if everything else has got better in the health service, the trend ought to be

in the opposite direction. My knowledge locally—you may say to me that this may be Barking and Havering Trust and GPs, etc—is that a lot of this is because GPs are not doing their jobs properly. What are you doing to drive that inexorable rise down from its current trend? What can you do?

**Sir David Nicholson:** There are a variety of reasons why those numbers have gone up over the years. Interestingly, in this particular environment, GPs are not the greatest amount. You are looking at demography, lifestyle, alcohol, mobile phone usage—all of those things are driving more calls coming through the system, so it is not actually the GP bit that is driving this. The point you generally make is absolutely right: one of the ways we can balance the NHS across the whole of its responsibilities is to reduce the utilisation of emergency services and urgent care generally. An example of the way we are tackling it is the roll-out of the 111 system, which we have started in the North-East, in Nottingham city and in a couple of other places. Patients can ring one number—a 111 number—and that will navigate them through the urgent care system, because part of the issue we have is that the default system at the moment is A and E. It can be very complicated for a patient, as you know, to navigate our services. That is a really important mechanism that we are starting to put in place and we will roll out over the next two or three years to bring those urgent care services together.

**Q110 Chair:** That brings me to two other issues. One is that further on in the report, on page 31, it says that you get a huge number of calls from nursing and residential homes, which are "often sources of unnecessary hospital admissions". This is really awful; one bit of the social care/health service is creating a pressure on another bit because people in the first bit are not doing their job properly, bluntly. I can see you are passing it on to somebody else to answer, but it strikes me that it is you guys at the heart of it who ought to be sorting this out.

**Peter Bradley:** You are absolutely right, and Helen does desperately want to say something about this. One of the things that we have found in the pathfinders on clinical commissioning groups is that this is an area that people can tackle very easily, in terms of reducing the number of omissions or the number of calls to the ambulance service, by early intervention, by GPs working with nursing homes, by making sure that we train, educate and support the staff in nursing homes to ensure that they do not make those calls.

**Chair:** Their turnover is relentless.

**Sir David Nicholson:** There is some really good evidence that it does actually work in those circumstances.

**Helen Medlock:** Last year—I think it was last year<sup>4</sup>—we did some work together on a demand toolkit to help all commissioners look at where the demand for ambulance services was coming from, and therefore where the areas were where we could do things differently and improve; residential care homes were particularly one area. Then we could develop the

<sup>4</sup> The toolkit 'Tackling Demand Together' was published in October 2009

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feedback from the ambulance service to say, “Which areas do we need to work on?” and get the support into that area, so that they can actually see there is a different way of working, partly by having ambulance staff going in and talking to them, but also by putting trained nursing support in, where we needed to, or putting extra pieces of work into support for those homes, so that patients could stay, if they were able to, rather than just being automatically taken to hospital.

**Q111 Chair:** If we look at this again in a year’s time, will those statements on page 31, paragraph 3.5, no longer be true?

**Peter Bradley:** I think the residential home one is one of the number of areas where the ambulance service receives high volumes of calls.

**Q112 Chair:** You accept—you have nodded your head—that this is a crazy waste of ambulance service money. You are taking action in one or two areas to cut it. Will we be able, in a year or two’s time, to track an improvement?

**Sir David Nicholson:** We should be able to track an improvement, certainly in the next two years. I cannot say that this time next year we’ll be sat here and you will see that improve significantly, but over two years I would say we could see that.

**Q113 Stephen Barclay:** As well as tracking that improvement, will that include changes to an advanced practitioner’s use? That paragraph says that advanced practitioners generate large savings, particularly in respect of nursing and residential homes, but currently they are being deployed alongside paramedics, which is not the best use of them. Paragraph 3.6 goes on to say that one service no longer employs advanced practitioners and “only two services were able to supply us with data on how their practitioners are deployed”. So, picking up on your point, Sir David, that in two years’ time it is going to be better, to what extent will all trusts, in two years’ time, be using advanced practitioners and all be able to provide the data that are currently missing?

**Sir David Nicholson:** My guess is it will be the opposite of that. First of all, in the work that is being done, particularly in the North-East of England, around nursing home and residential care utilisation, it has not been the advanced practitioners that have done the work; it has been basic nursing education that has had the benefit there. With regards to advanced practitioners, based on the information that we have for the ambulance services, the numbers will probably go down. There are two reasons for that. One of them is that it is quite difficult to connect the individuals—because there are only 700 of them across the country out of 20,000 staff—with where the need is, so how do you get that very small number to the places where you need them? It is very difficult to do it in a sensible way. The other point is that when we started off down the road with paramedics, you could do the training in 12 weeks. Now it is a three-year university degree course. So the paramedics are much more capable of doing the kind of work that in the past the advanced practitioners could have done. From the ambulance service point of view, the

paramedics are much better value for money because they are more flexible and can be used across the service.

**Q114 Stephen Barclay:** In essence, what you are saying is that you take issue with the NAO finding that says that advanced practitioners are able to generate large savings; you are saying that you will do that through other ways.

**Sir David Nicholson:** I think they can and individuals do, and they do really good work, but we think a better model would be the more widespread use and availability of paramedics.

**Q115 Stephen Barclay:** By what date, then, will we have an agreed approach to measuring staff utilisation across the sector?

**Peter Bradley:** Across which sector?

**Stephen Barclay:** Paragraph 3.3 says, “Services measure their staff utilisation in different ways. Some use the average number of times a crew is called out in a given hour; some use the number of hours worked as a proportion of hours available; but some services use neither. This means that performance in relation to staff utilisation cannot be compared across the sector.” Coming back to Sir David’s point that things are going to be much improved in two years’ time, within the next two years are we going to have a consistent set of data on staff utilisation?

**Sir David Nicholson:** The system will be set up to do it within three months.

**Q116 Stephen Barclay:** So we will have it in three months’ time.

**Peter Bradley:** We are very confident that we can supply utilisation rates across England in the same way in three months.

**Q117 Chris Heaton-Harris:** Throughout this Report, and throughout what you are saying, it is obvious that the ambulance service has come a long way over the last period of time, but actually there are a lot of benchmarks that are set for you in this Report that you are going to strive to improve on, so that you get closer to a much better service in the not-too-distant future. Equally, in this Report, there are these massive regional variations. One thing we have not got to the bottom of is how you spread best practice across the service. I assume that is your role, under one of the hats that you wear, but I have not got the confidence I would really like to have about how it is happening now, and how it is going to happen in the future.

**Peter Bradley:** Thank you for that question. One of the few issues that I had with the NAO Report in its earlier draft was that it implied that the ambulance services do not work well together. In fact, I would argue quite strongly that we work better together than any other part of the NHS—sorry, Sir David—and any other part of the emergency services. In fact, last week, we published a report on behalf of the ambulance service for England saying what we have done in the past six years. I am a critic of the ambulance service myself, and a supporter; I look at both good and bad in the ambulance service. I chair

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every four weeks a meeting with all the ambulance service chief executives and we have a national work programme to improve things, from procurement to sickness management and benchmarking, and I think we have done a huge amount to share best practice. We are working together on the Olympics. We have a national mutual aid agreement. The ambulance services across England welcome the NAO Report, and we are going to work nationally on the recommendations.

**Chris Heaton-Harris:** That is exactly what I wanted to hear. So we could possibly come back in a year's time, or the NAO—

**Q118 Amyas Morse:** Can I just say—sorry to butt in—that is great? Thank you very much for those positive sentiments. That is a very good response. I just want to be sure I understand, though. If you are in a particular regional ambulance service and you say, “This is the best practice” and they do not do it, what happens then?

**Peter Bradley:** We are pretty good. It is one of those things. It is an unwritten agreement; it is a bit hard to explain. It is just the way things have evolved. I have no real power over the ambulance services, but when David Flory asked me to try and make something happen nationally that we needed to on a major incident issue, I think we were able to do that within two weeks across England. So we are agile and flexible in a way that other organisations are not, in my view.

**Q119 Chair:** What happens when you all become individual trusts?

**Peter Bradley:** I think that was the first question you asked.

**Chair:** Yes, I am not sure you will be able to sustain that.

**Helen Medlock:** That is one of the reasons we got together as ambulance commissioners, because it was clear that the ambulance trusts were working well together, but as individuals back in our patches we didn't know enough about what was happening around the country, so we got together and we are sharing best practice as well. If I find out that somebody in the North-West is doing something fantastic, then I can take it back to our area and develop it with our trust as well, so we have got that mechanism going on at the same time as we have the ambulance trusts working together.

**Peter Bradley:** We now have two foundation trusts, and we hope to have three in the next few months, and we have a commitment from the Association of Ambulance Chief Executives. We have a commitment from all colleagues that notwithstanding the FT issue, we will all continue to work together in the interest of the profession.

**Q120 James Wharton:** Very briefly, I want to say two things. You waved a report at us; would you be so kind as to send us a copy, and a note saying how much staff time and printing costs went into that, and also how much you spent on that? Also, it appears that right across the country you are measuring data in different ways and getting different information,

and one of the challenges, we often find, is comparing that, and actually trying to figure out what it means. When are we going to have perfectly uniform and comparable measures for the ambulance service, and if we are not, why are we not going to have them?

**Peter Bradley:** I believe that 90% of the information that we have is comparable and benchmarkable—if there is such a word—and is transparent and open right now. There are a few areas that the NAO has identified, in particular around utilisation rates, that we can point to, but there are hundreds of examples where we have shared information routinely and it is all comparable. The most important measures that we have and will have are the new clinical quality indicators, which will show patient outcomes for stroke, trauma, and cardiac care nationally. I am really excited that, as a paramedic and a chief executive—an old paramedic—we, for the first time, will be able to say, “In London, stroke patients receive this care and this outcome. Patients in other areas received that.” It will mean that those in charge of an ambulance service can say, “Right, I noticed that that service does better than we do. How can we work together to try to develop our service?”. This is a really important development for our service. It is a big development, and the one I am most excited about.

**Q121 James Wharton:** Mr Barclay has just very kindly passed over a copy of the report. On page 40, at 3.28, it says, “Whilst they also share best practice, cultural differences between the services and the differences in data definitions inhibit the take-up of good practice.” Is that erroneous?

**Peter Bradley:** It is not erroneous in some areas, but I again took exception to that aspect of the Report when it first came out, in an earlier version, in that it implied that we do not actually have any comparable information; we do. We have been very exacting with the new clinical quality indicators, the new 11, to ensure there is no variation in view as to what they mean. This will be on a public website across England.

**Sir David Nicholson:** From when?

**Peter Bradley:** From next month; from July, for the first time, we will have information for every ambulance service comparable in the same way.

**Q122 Stephen Barclay:** Very interestingly, you said you have no power to challenge. One of the issues that interested me is the outliers, so: a) whether there is effective benchmarking; and b) whether the outliers are being challenged. Can I just clarify, where there are outliers in the ambulance service, is it your role to challenge those? Is it Sir David's, as the accounting officer? Or is it seen that these are independent organisations, and is it for their boards?

**Peter Bradley:** I am not sure what you are talking about. If you thought I said that, I did not say that we did not have the power to challenge. There is a huge amount of peer pressure among colleagues. The 11 ambulance medical directors meet to look at clinical outcomes measures and ask why we are not doing as well as you are. So there is the in-built peer pressure of the 11. In my role, it is purely around that people respect my role and hopefully me, and therefore we

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never have an issue. If I ask them to do something, they do it, but they could tell me to get lost.

**Q123 Stella Creasy:** I just wanted to go back to the sentence following the one that Stephen just read out, which says, “Services told us of their concerns that the sharing of best practice may be inhibited if services envisage being in competition with one another in the future.” In our earlier conversation, you clarified that there would not be any ability to vary what you pay for in terms of the core functions with the new system. Will you be able to vary what you pay for, what you purchase and who you purchase from with the added value stuff?

**Sir David Nicholson:** There is an area where there is quite a lot of competition at the moment, which is in the patient transport services, which are the kinds of services that take you to and from outpatients and all of that. There is a history of competition in that area.

**Q124 Chair:** But that is tiny. At the beginning, we heard Mr Flory say that was how much?

**David Flory:** £400 million.

**Peter Bradley:** Of what you spend?

**David Flory:** Yes.

**Chair:** It is tiny, right? The main money goes on A and E.

**Q125 Stella Creasy:** In the future, in the added-value section, just so we are clear, will GPs be able to say, “Well actually, we do not just want to purchase our transport from this ambulance service rather than that ambulance service; we also want to purchase some of our community outreach stuff?” They will, so they will be able to pick and mix different ambulance services.

**Peter Bradley:** This happens now. I know we are aware of some ambulance services that have been offered to run a GP out-of-hours function, but there is mutual agreement at the moment; we say, “Shall we bid for this?” . In the future, that will change, no doubt, but it is not an issue.

**Q126 Stella Creasy:** How do you think that will change?

**Peter Bradley:** Well, perhaps ambulance trusts. I am not an expert in this area, so I am getting slightly out of my depth here; I am not quite sure about the co-operation versus the competition aspect of things. At the moment, ambulance services can and do bid for pieces of work in other areas. In the future, I do not know.

**Q127 Stella Creasy:** Does that worry you? Obviously, what this Report says is that could cause people not to share best practice, because frankly there is a big difference between competing on maybe offering different transport services and competing on offering paramedic services, which are much more profitable.

**Peter Bradley:** For the core ambulance service, that will not change.

**Q128 Stella Creasy:** Yes, we had that earlier and I agree with that. For the core, it is non-negotiable what

you can buy, but if you are a GP commissioning services under the new system you will be able to commission and put out to competitive tender between ambulance services—

**Peter Bradley:** One is a case in point. That is happening now. I respect that other ambulance services, when bidding for pieces of work such as the 111 system, might not want to share their bid with me as a chief executive. That is the way it is—no problem.

**Q129 Stella Creasy:** As this Report says, that is going to inhibit the sharing of best practice.

**Peter Bradley:** On tendering for pieces of work; not on best practice for clinical care. Absolutely not for clinical care.

**Q130 Stella Creasy:** But clinical care is one of the things that is separate from the emergency services, isn't it? It is the other work that should be related, isn't it, that is up for grabs?

**Peter Bradley:** I cannot quite get the point.

**Q131 Stella Creasy:** Frankly, Mr Bradley, I would presume that if you are commissioning paramedics to do things in the community, it has a value to clinical care. It is not just a nice thing for them to do; it has a value to the care that we are going to get from this service.

**Sir David Nicholson:** Yes.

**Q132 Stella Creasy:** So it will be affected by this tension between co-operation and collaboration, won't it?

**Peter Bradley:** I do not believe so.

**Q133 Austin Mitchell:** You are thinking in a London context.

**Helen Medlock:** The clinical indicators are very much on the core service.

**Q134 Chair:** It might help if I ask some questions about the clinical indicators. We have talked about them quite a lot. They are on page 29, figure 17; I assume those are the ones that you are talking about, aren't they? These are the ones you are so excited about. Whether or not they are achieved is partly what you do, but it is also what acute trusts do and what commissioners do—that is, the GPs. This may be a question to Sir David; how on earth are we, in following the pound, going to be able to assess the contribution to these laudable outcomes from the money, the taxpayer's pound, that goes into the ambulance services?

**Sir David Nicholson:** The clinical quality outcomes for ambulance services have been designed by the ambulance service itself; they are the ones that they believe are the best reflection of the outcomes that they want to achieve, and they are the ones that they can effect most themselves.

**Q135 Chair:** Have they been agreed by the acute trust body, you, the GPs, and all the other players in the world?

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**Sir David Nicholson:** Everyone has had their six penn'orth in all of this, that is absolutely true, but it has come from the front line, in that sense, as opposed to a politician or a bureaucrat or whatever other beast that does these things normally. All of those things have that. You are absolutely right; part of it is that if you look at the ones for A and E, which we have not got at the side of this, they are complementary. Actually you can see how they connect with each other. A good example would be around A and E, about the indicator around the handover<sup>5</sup>, so you have got the A and E department, who are being measured by how effective the handover is, and you have the ambulance service being measured on how effective the handover is, and in that way you can integrate services together. This is the argument for service integration. The way you get the best complete outcome for a patient is by integrating those different pieces together.

**Q136 Chair:** I am a bit worried about how you actually populate data that would be meaningful for us to look at VFM. Let's take outcome for cardiac arrest, number two there. Obviously, getting somebody who has had a cardiac arrest quickly to the hospital, the nearest brilliant unit, is hugely important. When we look at that, are we going to be able to say, "The contribution from the taxpayer's pound towards that has been improved by x"? We want to populate it and then track it.

**Peter Bradley:** I think the cardiac arrest one is the best example, because that is the gold standard measure internationally for ambulance services. You arrived to a patient with no pulse, who was not breathing. When you got to hospital, were they alive, resuscitated successfully, and crucially were they discharged from the hospital alive and still alive 12 months later? That is the most important single measure clinically for ambulance services. Up until now, only two ambulance services in England had measured that and we had no idea about how we could compare ourselves with, say, Seattle, which has a 40% survival-to-discharge rate and New York, which has a 2% survival-to-discharge rate. This will tell us how effective our ambulance services are at providing advanced life support out in the field and the impact it has upon patients.

**Q137 Chair:** And your contribution, as opposed to the acute trust's?

**Peter Bradley:** Our contribution to that is significant, because we have got the double measure of, "Did the person return to spontaneous circulation when they got to hospital?" So, "Were they alive when they got to hospital?" And crucially, "Were they then discharged?" In London last year, 97 people walked out of hospital who otherwise would have been dead; seven years ago, that was 27. That is a crucial measure for us. As Sir David said, we will review this in 12 months' time. This is the first year; we have got a

<sup>5</sup> Ambulance handover is not one of the ambulance Clinical Quality Indicators but is within national 'sit rep' reporting and is within both acute and hospital contracts. Acute hospitals have to measure the time to initial assessment which, for ambulance patients, is essentially similar to the handover time

national agreement, as with the A and E indicators, to review them.

I was going to say that Professor Matthew Cooke, who is the Clinical Director for Urgent and Emergency Care at the Department of Health, among other roles, is looking now with colleagues to develop a set that goes all across urgent care, so, as you have said, Mrs Hodge, we can actually measure the patient pathway and hopefully over the next 24 months we will see an overarching set that can measure the whole pathway of patient care.

**Chair:** Good.

**Q138 Stephen Barclay:** On a related point, we have not touched on paragraph 2.4, the cost variation in terms of calls. I was struck that in the North-East, the cost was £144, compared to £216 for Great Western—a £72 variation per call. In terms of cost per incident, there is a £75 variation, which is a pretty dramatic differential. Mr Bradley, you were saying earlier that outliers were going to be addressed largely through peer pressure, and I wanted Sir David's thoughts, as the accounting officer, on the extent to which you are concerned by such variations. Of course there are some factors beyond your control, such as location and nature of accident, but there are factors within your control. What would you expect that to be in two years' time? Have you set measures or targets on which you are holding individuals accountable? What is the plan to bring those variations down?

**Sir David Nicholson:** No, clearly, we would expect those variations to get smaller, because they need to get smaller to be able to implement the national tariff arrangements and all the rest of it. The squeeze to reduce the variation in the next two or three years will be significant. Of course, all ambulance services have the same degree of requirement to deliver efficiency savings as the rest of the NHS, so they all have to deliver 4%.

**Q139 Stephen Barclay:** If they do not, who is responsible?

**Sir David Nicholson:** If they do not deliver their efficiency savings?

**Stephen Barclay:** If these variations stay?

**Peter Bradley:** First of all the board of the organisation is responsible, then ultimately the accounting officer is responsible for it.

**Chair:** That is the same thing, but it is a bit of the localism/centralism issue, which we are hoping to get light on from the DCLG Permanent Secretary. Final question from Austin, and then I think I am going to close it.

**Q140 Austin Mitchell:** This move to pick-and-mix services might be okay in London where you can bring in neighbouring services, but if you are going to do it in Grimsby, we could only commission them from Rotterdam. No service can cross the boundary to Grimsby. I just want to ask you about a point made in the written evidence from the Ambulance Service Network, which says, in 3.2, that South East Coast Ambulance Service was commissioned to provide critical care practitioners as paramedics with extra clinical skills. The evaluation showed that this was

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valuable and they concluded that CCPs would easily meet the National Institute for Health and Clinical Excellence cost effectiveness criteria if you were to compare the introduction of CCPs with the introduction of a new drug. Suppose that whoever is commissioning an ambulance service in my area decides not to commission clinical care practitioners. I think as an MP a section of the public thinks it would be a good thing if they did, because it will improve life chances. What do we do?

**Sir David Nicholson:** At the moment?

**Q141 Austin Mitchell:** No, in the new situation.

**Sir David Nicholson:** In the future? You would have two options really; one is to talk to your clinical commissioning group, who are responsible for commissioning your care.

**Q142 Austin Mitchell:** And they say we cannot afford it.

**Sir David Nicholson:** Or the second area is the Health and Wellbeing Board of your local authority, which is a forum that brings all the commissioners of services together and bases the commissioning decisions on the needs as assessed by the local population. It may be that there are other priorities greater than that particular one for that particular locality, but that is where that decision is taken.

**Q143 Stephen Barclay:** I represent a rural area and one of the issues that happened there was that ambulances were being moved to Cambridge, because it was far easier to hit targets in Cambridge than it was to hit targets in areas like Littleport in my constituency, which were harder to get to. It was a logical management decision to up your numbers by going to the easier areas to reach. Buckinghamshire, Oxfordshire, and Hampshire Councils did a study that they brought out in February 2010 looking at this, which had the conclusion that there was a two-tier service between urban and rural areas. I just want to understand why you have not adjusted your deployment protocols to reduce the tail of responses, because you are not measuring, as far as I understand it, the maximum times. I have had some quite shocking constituency issues, where basically because the ambulance has missed its target, whether it misses it by a couple of minutes or an hour makes no difference. So people have been left in rural areas in a pretty shocking position because managers are saying, "Well, actually I can hit my numbers by targeting ambulances at the urban areas."

**Peter Bradley:** That is a good point, and the Chief Executive of the ambulance service in Hampshire, South Central Ambulance Service, took that matter very seriously, that particular report from the HOSC, and has worked very hard to try to reduce that tail. In fact, he has focused very heavily in the past 12 months to try to reduce the length of time it takes to get an ambulance to those calls. Inevitably, you try to do the most good for the most people in the shortest time, and therefore in towns and cities you will have more resources, and in rural areas you will wait longer. In fact, some years back, when I started in the ambulance service, we had separate rural and urban times, but

that was removed because I thought that that was unfair.

It is a continuing challenge for the ambulance service: how do you provide a good local service that is heavily utilised? The issue we have got is that in some of those rural areas the utilisation rates are 10%; so you have got a paramedic sitting there but only used 10% of the time—like the fire brigade in some parts. Back to the earlier point of advanced practitioners, without going off on a tangent, one thing I think will happen is that we will have some advanced practitioners in the service, but increasingly they will be working in GP surgeries so they can multitask, and we are seeing it now in some parts of East of England; they are working with GPs in their practice, but also they will respond to calls.

**Q144 Stephen Barclay:** The irony is that in Littleport they were taken out of the GP surgery and moved to a roundabout in order to get to Cambridge quicker. Perhaps you could let us have a note, or at least write to me individually, just with your thoughts on whether the protocol could be looked at again. I appreciate the point you are making. There is an issue for rural constituencies. It is not easy, and I recognise that, but perhaps that could be looked at again; I raised it with the East of England and got a totally unhelpful response, so if I could ask you to look at that, that would be helpful.

**Peter Bradley:** Yes, absolutely.

**Q145 Chair:** I want to draw it to a close and then I am going to ask Sir David a cheeky question. I am just warning him. Can I start by saying thank you very much? I thought that was a very good evidence session and thank you for the very direct, open and frank way you dealt with our questions. I take it as a general conclusion that the way forward in this particular area is to have probably more prescriptive national control over how you drive out inefficiency, which we will reflect on. With better comparative data, very shortly and within two years we will start to see regional variations going down a lot, and efficiency, with other players in the field playing their role properly. So, we look forward to monitoring that over time. Thank you for the evidence.

Now, my cheeky question is a constituency one, and is that the Care Quality Commission announced this morning that they are going to do a full investigation of the Barking, Havering and Redbridge Trust Hospitals, and they are going to be in there for eight weeks. I was just wondering whether you were fully committing to implementing the recommendations they come out with?

**Sir David Nicholson:** Absolutely. We will obviously work with the CQC around that. It is a very important hospital for a whole variety of reasons—

**Chair:** It is to me.

**Sir David Nicholson:**—not least of all because it is in your constituency. That is not the reason we are doing it. It has had problems in the past and there is a new chief executive in there, as you know; we want to get those issues sorted out as rapidly as we can. We will work very closely to make that happen.

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**Q146 Chair:** So you will fully implement their recommendations.

**Sir David Nicholson:** We are absolutely committed.

**Chair:** Thank you.

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# Written evidence

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## Written evidence from the NHS Confederation

### AMBULANCE SERVICE NETWORK/NATIONAL AMBULANCE COMMISSIONING GROUP

#### KEY LINES ON FUTURE MODELS FOR AMBULANCE SERVICE COMMISSIONING

##### EXECUTIVE SUMMARY

##### *Equity and excellence: Liberating the NHS*

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

##### *Ambulance services and commissioning levels*

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

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

To deliver safe, effective and resilient care for patients whilst also being responsive to local needs and priorities, the ASN and NACG would like to propose that the different elements of ambulance service provision are commissioned at the most appropriate "levels" in the system. This could be either at individual GP consortia, by groups of consortia (multi-consortia level), nationally or "regionally"<sup>1</sup> by the NHS Commissioning Board; effective collaboration between these commissioning "levels" will also be essential.

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

##### *Local unscheduled care services*

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

##### *NHS 111 services*

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

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

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

##### *Emergency Preparedness services*

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

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

### *Patient Transport Services*

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

#### *Next steps*

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

## 1. BACKGROUND AND INTRODUCTION

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

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

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

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

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

- To contribute effectively to national, regional and local leadership of emergency and urgent care policy and delivery.
- To ensure that over the next two years, approaches to commissioning ambulance services deliver improvements in quality, efficiency and productivity while maintaining performance and stability.
- To support the development of new commissioning models that will enable ambulance service to be commissioned in future as:
  - (a) Part of an efficient, integrated local urgent care pathways.
  - (b) Effective providers of emergency care for life threatening conditions.
  - (c) Services that have the capacity and capability for ongoing emergency preparedness and system resilience to meet changing.

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

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

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

It also argues that in designing appropriate models for ambulance commissioning it is important to recognise that there are both transactional functions (contracting, payment etc.) to deal with and more transformational service re-design issues to tackle, and that the process and timescales for approaching these may be different, but related.

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

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

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

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

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

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

### *Implications for ambulance service commissioning*

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

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

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

## 3. AMBULANCE SERVICES AND COMMISSIONING LEVELS

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

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

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

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

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

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

We believe that these different elements are most appropriately commissioned at different levels either by individual GP consortia, by groups of consortia (multiconsortia level) nationally or “regionally” by the NHS Commissioning Board but that the interdependencies between them mean that effective communication and collaboration between commissioners at these different levels will be essential.

A robust transitional approach to ambulance commissioning will be required over the next 12–30 months to ensure that the NHS gets the value for every tax payer pound.

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

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

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

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

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

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

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

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

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

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

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

- The data generated from 111 calls is quickly used to inform GP commissioning consortia of changes in levels of demand, appropriateness of local service offer and patient experience and outcomes measures.

### 3. 999 services and the infrastructure to manage calls where a speedy response is needed to life threatening individual incidents

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

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

Regional or lead commissioning for 999 services would:

- Provide a co-ordinating role for formal contract and performance management of ambulance providers across the large geographical footprint needed for 999 services whilst providing outcomes information for each GP consortium.
- Provide a co-ordinating role with local GP consortia within the region in the development of a regional integrated unscheduled care strategy to ensure high quality emergency 999 service coverage and a continued emphasis on the management of demand.
- Enabling local GP consortia to collaboratively set the commissioning intentions balancing the need for regional consistency and appropriate localization.
- Aid the further development of specialist pathways for stroke, trauma, cardiac and vascular services etc.
- Avoid the risk of cutting across the good, clinically evidence work of joining up specialist pathways eg for stroke, trauma, heart attacks which have a regional focus.
- Aid regional pathway initiatives for example around big cities for particular patient groups.
- Enable patient, public and stakeholder engagement in the strategic model for urgent and emergency care.

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

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

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

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

### OTHER NATIONAL REQUIREMENTS

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

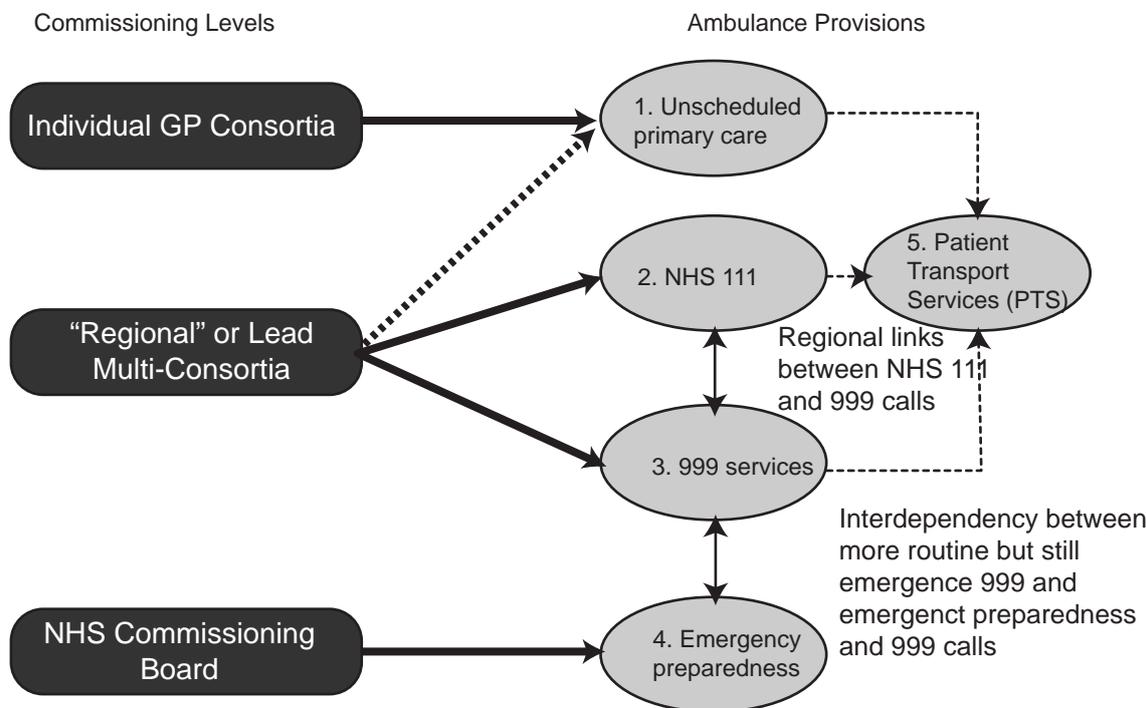
As national services, we believe these should also be *commissioned centrally at a national level*. It will be important to ensure that locally developed ambulance commissioning plans and specifications take into account the need for ambulance providers to respond effectively and efficiently to these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

### 5. Patient Transport Services (PTS)

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

Another area for commissioners to consider is the potential for commissioning integrated health and social care patient transport services, particularly in rural areas.

These levels for the different types of service can be shown in the following diagram. This builds on the individual patient and practice level commissioning responsibility that all GPs already hold to ensure the patient is at the centre of their own care.



#### DEVELOPMENT OF THE COMMISSIONING MODEL

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

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

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

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

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

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

#### CONCLUSION

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

### Written evidence from the NHS Information Centre

#### UPDATE ON PERFORMANCE OF THE AMBULANCE SERVICE

NATIONAL STATISTICS ON THE AMBULANCE SERVICE, PRODUCED ANNUALLY BY THE NHS INFORMATION CENTRE

##### Introduction

1. This note provides an overview of the activity and performance of the ambulance service for 2010–11, using data published on 23 June by the NHS Information Centre. The full report can be accessed through the website [www.ic.nhs.uk](http://www.ic.nhs.uk).
2. There are no published costs data more recent than the 2009–10 data used in the NAO report *Transforming NHS ambulance services*.

##### Summary of performance

3. There has not been any significant change in performance against the targets compared with previous years and call volumes continue to rise.
4. The table below compares 2010–11 data with 2009–10 data presented in the NAO's report.

<i>Data</i>	<i>2010–11 (new data)</i>	<i>2009–10 (data in report)</i>	<i>Relevant figure(s) in the NAO report</i>
Number of calls	8.06 million	7.87 million	Figure 3, Figure 4
Number of calls resolved through telephone advice	0.24 million	0.22 million	Figure 4
Number of incidents	6.59 million	6.42 million	Figure 4
Number of patients treated at the scene	1.8 million	1.6 million	Figure 4
Number of emergency journeys	4.9 million	4.7 million	Figure 4
Percentage of category A calls responded to within 8 minutes	74.9% variation across ambulance services: 72.4% to 77.5%	74.3% variation across ambulance services: 70.8% to 78.3%	Figure 1, Figure 12
Percentage of category A calls responded to within 19 minutes	96.7% variation across ambulance services: 93.5% to 99.0%	96.8% variation across ambulance services: 92.7% to 98.8%	Figure 1, Figure 12
Percentage of category B calls responded to within 19 minutes	91.2% variation across ambulance services: 87.0% to 95.6%	91.0% variation across ambulance services: 85.9% to 95.8%	Figure 1, Figure 12

June 2011

### Written evidence from the Ambulance Service Network

PUBLIC ACCOUNTS COMMITTEE EVIDENCE SESSION 29 JUNE 2011

The Ambulance Service Network (ASN) is part of the NHS Confederation and represents the 11 ambulance trusts in England; those from the devolved administrations of Northern Ireland, Scotland and Wales, and the ambulance services of the islands of Guernsey, Jersey, Isle of Man and the Isle of Wight.

The main aim of the ASN is to raise the profile of ambulance services and to encourage these services to achieve greater integration with the wider health system.

The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS. We have over 95% of NHS organisations in our membership including ambulance trusts, acute and foundation trusts, mental health trusts and primary care trusts plus a growing number of independent healthcare organisations that deliver services on behalf of the NHS.

We are pleased to have the opportunity to submit evidence ahead of the committee's evidence session on 29 June 2011

## EXECUTIVE SUMMARY

- The Ambulance Service fully endorses the National Audit Office report *Transforming Ambulance Services* recommendation that ambulance services have “a pivotal role to play in the performance of the entire urgent and emergency care system”.
- The NHS chief executive Sir David Nicholson has highlighted the strategic importance of the ambulance service in pointing out that ambulance services and their staff, while responsible for only two% of total NHS spend, make decisions effecting 20% of spend later on as patients move through the NHS system.
- The Government’s changes to the Health and Social Care Bill should be an opportunity to make sure a more strategic approach is taken to the commissioning of ambulance services.

Ambulance Services are already using the clinical skills of their staff to offer new services. These services are helping to both improve patient care and deliver more efficient NHS care.

### 1. *The Role of Ambulance Services*

1.1 The Ambulance Service Network was launched in 2008 with the express aim of showcasing the role Ambulance Services can play in working with the rest of the NHS to improve care right across the board rather than simply taking people to A&E departments quickly.<sup>i</sup>

1.2 The modern ambulance service cares for “patients of all ages and with all types of conditions: from mothers in labour and newborn babies to those at the end of their lives, and from the critically ill and injured to those suffering from chronic diseases and minor conditions”.<sup>ii</sup>

1.3 The Ambulance Service Network fully agrees with the National Audit Office report recommendation that the ambulance service should have a central role in helping to improve and link up the urgent and emergency care system.

1.4 New policies such as the move to evaluate performance more on the basis of outcomes rather than solely on response time and the creation of a new NHS 111 number for urgent but not life threatening cases offer real opportunities for the ambulance service and the NHS to improve patient care.

### 2. *Commissioning and the need for clarity*

2.1 However, in order to fully deliver on its potential, the ambulance service needs to be clear on how commissioning arrangements at local, regional and national levels are co-ordinated so that services can be joined up in a strategic manner.

2.2 The ambulance service is perhaps unique in the NHS in that it is a national resilience service at the front line of our response to major emergencies such as terrorist attacks, a regional provider of emergency care through 999 and, where future tenders are successful, the NHS 111 service, and a local provider of services such as patient transport.

2.2 As soon as the Government announced its original health reform plans in its white paper, the Ambulance Service Network worked with the National Ambulance Commissioning Group and the British Medical Association to start looking at the model for commissioning NHS ambulance care. A copy of this document is attached.

2.3 The key point of the document was a recognition from across ambulance services, commissioners and the wider NHS that ambulance services have been most effective where the relationships with commissioners were more strategic rather than simply transactional or overly focused on contracts.

2.4 This is because many of the services ambulances offer require a regional or at the very least “supra-local” perspective and understanding of local health systems. The most obvious examples are serious trauma care and stroke care. A recent ASN publication on trauma care looked at the evidence internationally and from recent UK reports on trauma care and is clear that: “Improvements to outcomes are most likely to be achieved, according to the evidence, by organising services strategically at a regional level. No one part of the system is likely to achieve this on its own. Therefore commissioners and providers need to collaborate to improve the whole pathway of care”.<sup>iii</sup>

2.5 To illustrate this point further, the chief executive of the NHS has estimated that while ambulance services are responsible for less than 2% of the NHS budget, the decisions their staff make (such as which service to take patients to or whether they have the skills to be treated on scene) have an effect on 20% of NHS spend overall. Ambulance service leaders are clear that commissioning arrangements should reflect the fact that investment in ambulance services will produce savings elsewhere in the NHS system.

2.6 The Ambulance Service Network believes therefore it is vital that future commissioners of ambulance services, at every level, are co-ordinated together properly so that the full potential of the service as outlined in the National Audit Office report *Transforming NHS Ambulance Services* is realised.

2.7 One of the main changes to the Health and Social Care Bill, following the Government’s pause exercise, from an ambulance service point of view has been the introduction of new layers of accountability and oversight at regional and local levels especially.

2.8 The Ambulance Service network believes these changes should be seen as an opportunity to put the voice of the ambulance service and the urgent and emergency care sector into these oversight and planning bodies so that the joined-up care that offers the best for patients can be offered.

### 3. *Using the skills of ambulance staff to improve care and efficiency*

3.1 The future structures of commissioning are an important starting point for further improvement in the development of NHS ambulance services. This is because they are already so much more than simply an emergency patient transport service.

3.2 For example, South East Coast Ambulance Service was commissioned to provide Critical Care Paramedics (CCPs)—paramedics with extra clinical skills. The evaluation the trust commissioned into their performance showed that (CCPs) are potentially a key component in reducing mortality rates in the pre-hospital setting when coupled with the right support and integration with hospitals and emerging trauma centres.<sup>iv</sup> It also made it clear that CCPs would easily meet the National Institute of Health and Clinical Excellence cost effectiveness criteria if you were to compare the introduction of CCPs to the introduction of a new drug.

3.3 CCPs are just one example. All across the country in areas such as public health, care for the elderly, dementia care, and care for vulnerable children ambulance services are showing what they can offer to improve NHS care overall.<sup>v</sup> Most importantly in the context of the huge efficiency challenge currently facing the NHS, they are doing so in a cost effective way.

3.4 For example, evidence suggests that introducing trauma systems can reduce mortality rates by around 10%, more efficiently use the £300–400m spending on emergency care for major injuries and contribute to reducing the estimated £3.3 billion to £3.7 billion annual economic cost of trauma.<sup>iv</sup>

3.5 With effective commissioning arrangements, ambulance services have a key role to play in being the oil in these systems, using the skills of their staff to link up hospitals, rehabilitation services and primary care in a cost effective way for better patient care.

#### REFERENCES

<sup>i</sup> NHS Confederation Ambulance Service Network, 2008, A Vision for Urgent and Emergency Care—the role of ambulance services <http://www.nhsconfed.org/Publications/Documents/A%20vision%20for%20emergency%20and%20urgent%20care.pdf>

<sup>ii</sup> Ibid, page 2

<sup>iii</sup> NHS Confederation Ambulance Service Network, 2010, Implementing Trauma Systems: Key Issues for the NHS, page 4 [http://www.nhsconfed.org/Publications/Documents/Implementing\\_trauma\\_systems\\_report.pdf](http://www.nhsconfed.org/Publications/Documents/Implementing_trauma_systems_report.pdf)

<sup>iv</sup> Dr Ashok Jashapara, 2011, Critical Care Paramedics—Delivering enhanced pre-hospital trauma and resuscitation care: a cost-effective approach [http://www.nhsconfed.org/Publications/Documents/Report\\_Critical\\_care\\_paramedics.pdf](http://www.nhsconfed.org/Publications/Documents/Report_Critical_care_paramedics.pdf)

<sup>v</sup> NHS Confederation Ambulance Service Network, 2010, Seeing Ambulance Services in a Different Light: More than a patient transport service [http://www.nhsconfed.org/Publications/Documents/Factsheet\\_ASN\\_June\\_2010.pdf](http://www.nhsconfed.org/Publications/Documents/Factsheet_ASN_June_2010.pdf)

<sup>vi</sup> NHS Confederation Ambulance Service Network, 2010, Implementing Trauma Systems: Key Issues for the NHS, page 4

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