Low Acuity Community First Responders

Evaluation Report Phase 1: North West Ambulance Service Pilot Project

March 2023 *[v9 FINAL]*

helpforce

NHS North West Ambulance Service NHS Trust

Contents

Executive summary

The project

North West Ambulance Service (NWAS) launched a Low Acuity CFR (Community First Responders) pilot project in April 2022, using funding received from the NHS England Voluntary Partnerships Team. The project aimed to ease pressure on the ambulance service by utilising trained CFR volunteers to respond to 'low acuity' (less urgent) emergency calls. Clinically-led by a paramedic based in the Emergency Operations Centre (EOC), the *Low-Acuity CFRs* visit and manage many calls without the ambulance needing to attend.

The pilot was managed by Mark Evans at NWAS who is also Chair of the National Ambulance Service Responder Manager Group (NASRMG). The Group has representatives from all UK ambulance trusts, many of which operate a similar role to Low Acuity CFR and are potentially interested in being involved with a broader evaluation. The NASMRG group is run from the Association of Ambulance Chief Executives (AACE). AACE has also recently worked with UK ambulance service members to produce a new strategy for volunteering.

Evaluation approach

Using Helpforce's *Insight and Impact service* we are evaluating the Low Acuity CFR role across two phases. Phase 1, as reported in this document, analysed the performance data provided by NWAS over the pilot period to assess whether the role is delivering efficiencies for NWAS through ambulances no longer being required. Phase 2 aims to deliver a broader evaluation involving more ambulance trusts over a longer period, and against a broader set of beneficiaries and outcomes.

Key findings

Over the pilot project period of 25th April to 31st October 2022:

- Of the 375 Low Acuity CFR-assigned calls **77% resulted in non-ambulance attendance** (290 out of 375).
- Freeing up a total of **469 hours** of ambulance time.
- For category 3 calls, the average response time for Low Acuity CFRs was **99 minutes less** than the NWAS average*.

77%

of CFR calls resulted in non-ambulance attendance

469

hours of ambulance time saved

Conclusions & recommendations

The findings of this rapid evaluation shows the positive difference that the Low Acuity CFR pilot project is making to the NWAS ambulance service in terms of non-ambulance attendance, lower patient wait times, and ambulance time saved. We recommend that this role is adopted across all UK ambulance trusts, and that the necessary funding is provided to enable the necessary scale-up of support staff and CFR volunteers.

* see page 12.

Context: Ambulance Services

The role of ambulance trusts and their importance in the delivery of health and care

Ambulance services have a vital role to play in ensuring the effective delivery of urgent and emergency care and are increasingly being encouraged to link-in with primary care and community organisations to prevent avoidable hospital conveyances [1].

Although progress has been made in altering the traditional service models of ambulance services, the significant challenges caused by current demands, staffing shortages and delayed hospital handovers mean that ambulance trusts are unable to provide the level of safe service that patients expect and deserve.

"Demands on all services across the NHS are increasing, as are delays in handover of patients at emergency departments" (AACE) [2]

"In October 2022, the volume of longer handovers, and hours lost due to these delays, grew to unprecedented levels" (AACE) [3]

[1] *Planning to safely reduce avoidable conveyance - Ambulance Improvement Programme - NHS England and NHS Improvement*

[2] *Delayed hospital handovers: Impact assessment of patient harm - AACE*

[3] *National Ambulance Handover Delays – November 2022 report - AACE*

Context: expected standards

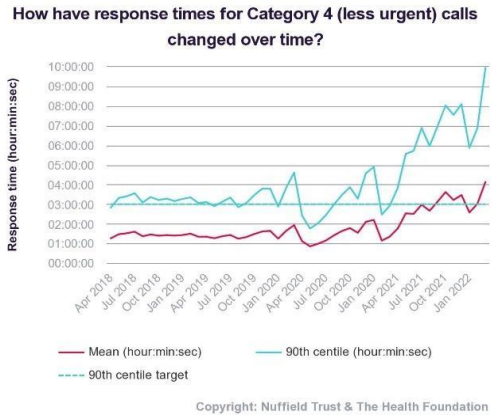
What service standards are expected of ambulance trusts and to what extent are these standards being met?

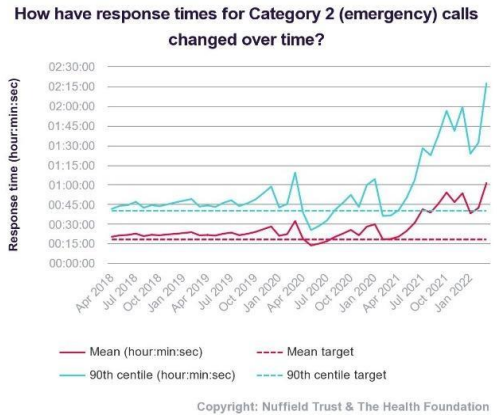
The current performance targets for ambulance response times in England were set in 2017. These targets are based on four categories. Category One is the most severe and Category Four is the least severe (see table for further details [4]). When a call handler receives a 999 call the patient's case is given one of the four categories and this determines the target time for an ambulance to reach the patient.

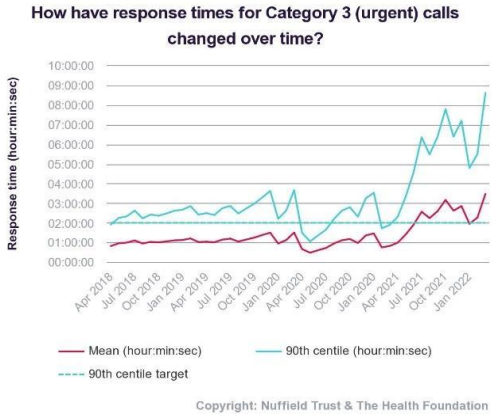
Performance against the targets in all four categories has fluctuated in recent years, but as can be seen in the charts, produced by the Nuffield Trust, there is a clear upwards trend in response times for all four categories of call, with targets increasingly being missed [5].

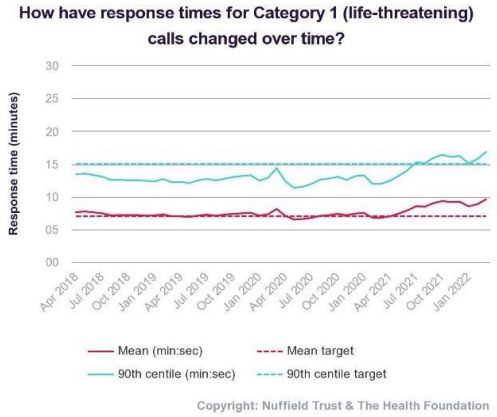
NHS emergency call categories and ambulance response time targets

Category	Example injuries/illness	Response target
Category 1: life-threatening	Cardiac arrest Severe allergic reaction	7 minutes on average, and 90% of calls in 15 minutes
Category 2: emergency	Stroke Severe burns	18 minutes on average, and 90% of calls in 40 minutes
Category 3: urgent	Late stages of labour Non-severe burns	90% of calls in 120 minutes
Category 4: non-urgent	Diarrhoea Vomiting	90% of calls in 180 minutes









[4] *Ambulance response times in England - an emergency?* House of Lords Library, Jan 2022

[5] *Ambulance response times -* Nuffield Trust, May 2022

Context: Community First Responders

What are Community First Responders, and how is this project different?

Volunteers have long played a valuable part in responding to requests for medical assistance in the community, going back to the 1800s. The volunteer's role in the delivery of ambulance services has continued to evolve and by 2019, according to The King's Fund, volunteers had "become a core part of the delivery of ambulance services" and "there is much to celebrate" [6].

The most common volunteering role across all ambulance services is the Community First Responder (CFR). According to AACE there are an estimated 10,000 CFR volunteers operating across ambulance trusts in the UK. This is not a standard role: there are variances between trusts in terms of the CFR role specification, the training that CFRs receive, and level of responsibility given.

Recent focus for the CFR role has looked specifically at supporting the high number of 999 calls related to falls. NHS England recently provided guidance to Integrated Care Boards (ICBs) with advice on extending CFR coverage [7]. And AACE published falls response guidance in 2020 including the role for CFRs in providing a volunteer response. [8]

NWAS is piloting a project aimed at focusing the CFR role on low acuity calls, using Winter Pressures funding received from NHS England. An assigned paramedic assesses 999 calls that are rated as low acuity (semi or non-urgent) and decides whether to deploy a CFR to the case. Able to reach patients local to them more quickly, the CFR can assess the case hands-on with the paramedic. Many of the cases can be managed without the ambulance needing to be sent.

This is not a new concept - seven of the eleven England ambulance trusts reported to NASRMG that they are running variants of the Low Acuity CFR role. The hope is that this evaluation will promote the impact and potential of this role and help all ambulance trusts to obtain the funding, leadership and clinical support to fully implement it.

[6] *Volunteering in ambulance services: Developing and diversifying opportunities – The Kings Fund, May 2019*
[7] *Going further for winter: Community based falls response - NHS England, October 2022*
[8] *Falls Response Governance Framework for NHS Ambulance Trusts - AACE, September 2020*

Context: Understanding the Low Acuity CFR role

How does the process for the CFRs on the Low Acuity pilot project work?

- Individuals apply to become a CFR volunteer (not specifically a Low Acuity CFR) through the NWAS website.
- Applicants are supported through the recruitment process and, if successful, undertake a four-day quality training course and additional online training to ensure they are equipped to undertake the CFR role. Once in post, new volunteers will shadow a more experienced CFR for a period until ready to operate alone.
- The Low Acuity Clinician (LAC) - a paramedic based in the EOC dedicated to this project - follows a procedure to identify calls that may be appropriate for CFR assignment. They review any 999 calls which have been triaged as a category 3, 4 or 5 ('low acuity') and then reviews the call against some key questions:
    - What's the nature of the call?
    - Does it fit within the scope of practice of a CFR?
    - Is it a simple or complex incident?
    - Are there any scene safety issues?
    - Are there any ambulances available in that area?
    - Is there a CFR that's available to attend?
- If the call is deemed appropriate for a Low Acuity CFR, the LAC contacts the relevant CFR by phone. If they agree they are able to attend the call is then passed to a mobilisation device that tracks the CFR's movement towards to call.
- Once on scene, the CFR assesses the patient and then contacts the LAC provide their assessments and observations of the patient. The LAC then may then ask the CFR to undertake additional assessments or queries, or the LAC will speak direct with the patient.
- The LAC determines if the situation still warrants an ambulance attendance, or if it may be feasible for the patient to use an alternative pathway such as visiting a GP or Urgent Treatment Centre, or able to make their own way to the emergency department.
- In some instances, if the incident is more severe than first anticipated the LAC will advise that the call category be upgraded.

Evaluation approach

Helpforce's approach to evaluating the impact of the Low Acuity CFR role has on the ambulance service, and the people involved

Using its established *Insight & Impact* evaluation service Helpforce follows a consistent methodology to determine the impact of volunteering roles on health outcomes. Target outcomes are identified across a range of beneficiaries representing the people and organisations involved, and then we collect the necessary data to prove and evidence the outcomes. We are approaching the evaluation of the Low Acuity CFR role through a phased approach.

Phase 1

A rapid evaluation of a pilot project at NWAS using existing operational data captured by the LAC. We are looking to answer the following questions about the project:

- Has it resulted in increased non-ambulance attendance? (And has that in turn lead to productivity gains for NWAS?)
- How much ambulance time has been freed up?
- Has it reduced response times and improved patient experience?

Additionally, interviews were conducted with three CFR volunteers and one LAC staff member to better understand their experience.

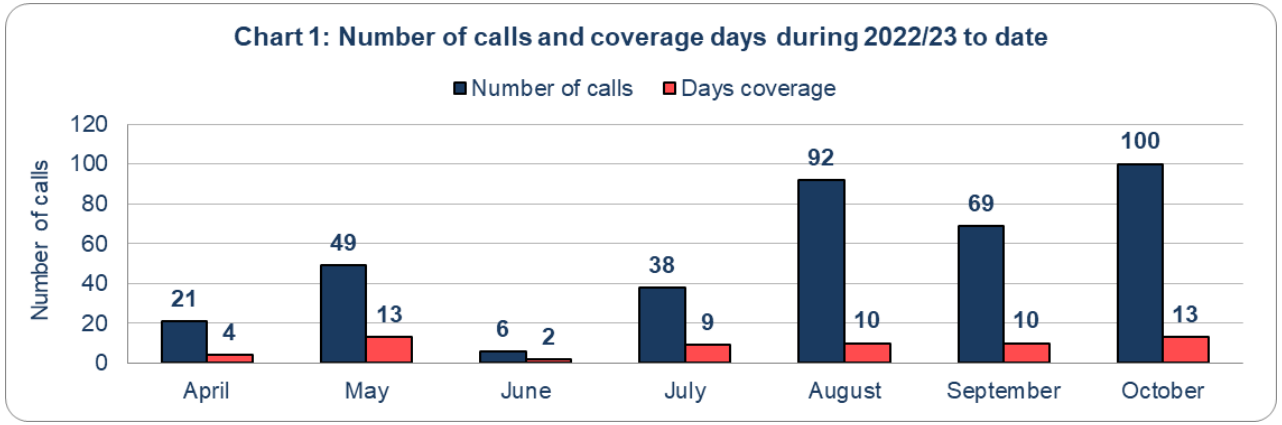
Phase 2

A more comprehensive evaluation of the role is being planned to start in 2023 with a broader scope for the evaluation design and involving more ambulance trusts operating a similar role.

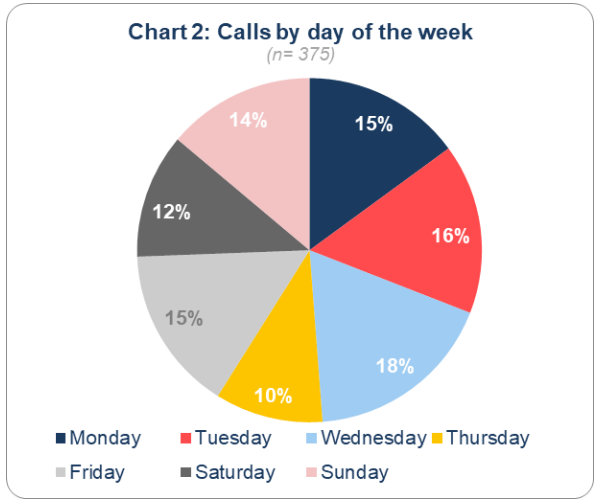
An initial outcome model for Phase 2 was co-produced with NWAS (right) identifying a broad set of target outcomes. To obtain the data to prove these outcomes we will work with the ambulance trusts involved to expand the data sets collected during operations, supplemented by standardised surveys we issue to key stakeholders.

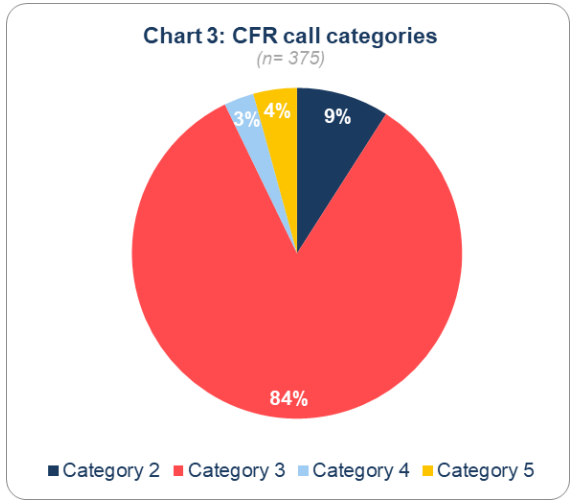
Impact: CFR activity during pilot project

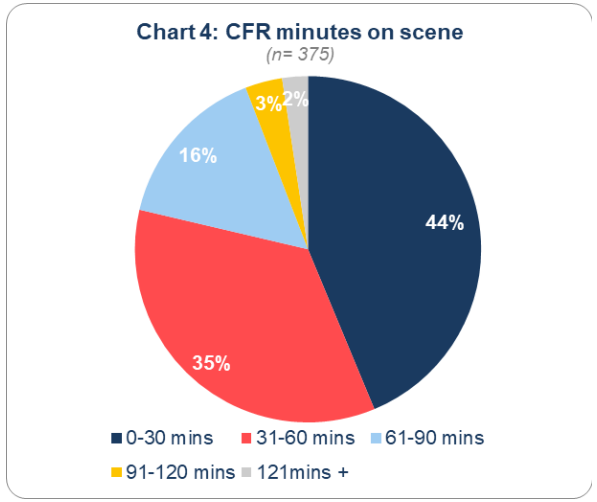
Details on all CFR-assigned calls during the Low Acuity CFR Pilot project



- Between 25th April and 31st October 2022, **375** Low Acuity-assigned CFR calls were completed.
- The LAC operated on 61 days across this period, meaning a Low Acuity CFR could only be assigned to a call on **32%** of the available days (61 days out of 189), at an average of 9 days per month.
- The majority of CFR call outs have been in response to **category 3 calls, accounting for 84% of calls.**
- In 79% of cases, the CFR is on scene for **60 minutes or less**.

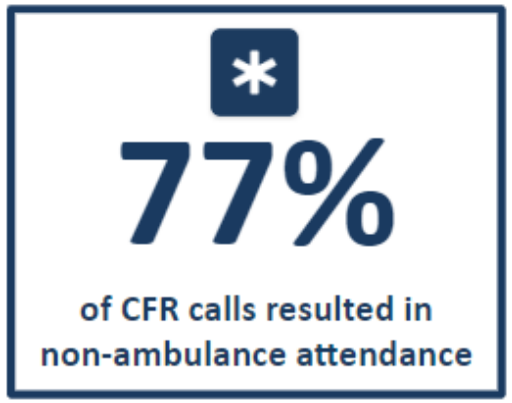






Impact: on the ambulance service

Did the Low Acuity CFR pilot project result in non-ambulance attendance?



Across the Low Acuity CFR-assigned calls analysed to date, **77.3% (290 out of 375) resulted in non-ambulance attendance** as it was no longer required. This was due to the LAC and CFR finding an alternative course of action, for instance:

- 80 calls resulted in patients making their own way to ED;
- 13 calls resulted in patients making their own way to an urgent treatment centre;
- 39 calls resulted in patients being redirected to community / other care resources such as the GP or district nursing teams;
- 158 calls did not require any further medical intervention at this stage, either due to the patient making the call by accident (e.g. fall pendant triggered), no longer being at the scene (potential hoax calls) or assessed as being OK to self-care or stay at home with family support.

As an aside, of the 22.7% of calls that were attended by an ambulance (85 of the 375), 37 were not conveyed to the local hospital emergency department. Therefore, in 87% of Low Acuity-assigned calls the patients visited by a CFR were not conveyed.

Impact: on the ambulance service

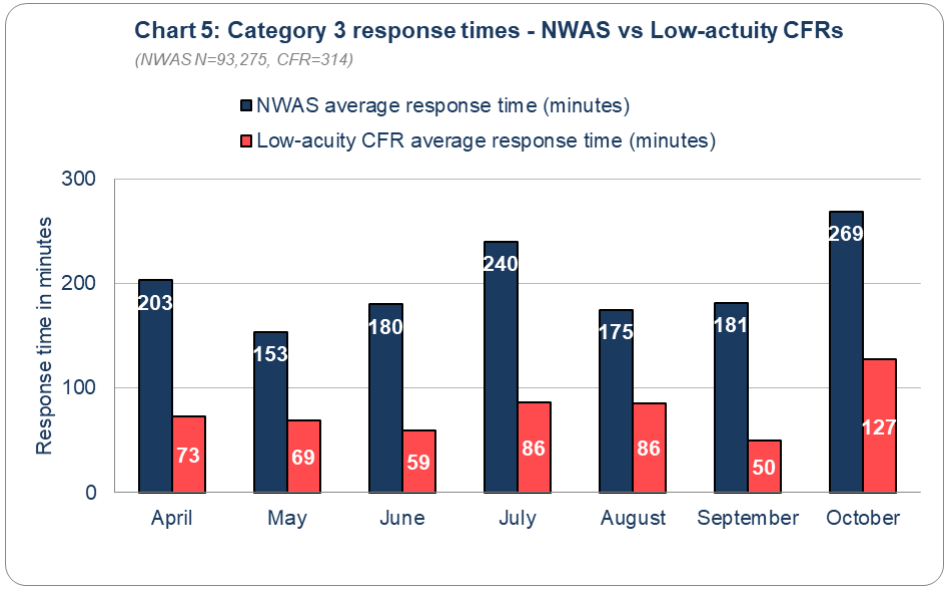
Did the Low Acuity CFR pilot project result in ambulance time saved?

- 290 of the 375 of the calls undertaken by Low Acuity CFRs resulted in an ambulance being cancelled. 210 of the 290 calls resulted in individuals not needing to go to hospital, and for the remaining 80 of the 290 calls the patients made their own way to hospital.
- When a patient is not conveyed to hospital, each NWAS call has an average job cycle time of 84 minutes. When the patient is taken to hospital the job cycle time is 130 minutes on average [9].
- We can therefore estimate that, during the pilot period, **469 hours of ambulance crew time has been saved**.

[9] *Data has been obtained from internal NWAS case recording systems for the period of 25th April to 31st October 2022. Job cycle times are calculated by mean time per call category. Job cycle times for calls that do not result in hospital conveyance are based on a return mobile to scene time plus time at scene. Job cycle times for calls that do result in hospital conveyance are based upon the sum of mean mobile to scene, time at scene, scene to hospital and turnaround times.*

Impact: on the ambulance service

What difference did the pilot project make to response times?



Average response time for category 3 calls

April to September 2022		April to October 2022
3 hrs, 7 mins	vs	1 hr, 28 mins
North West Ambulance Service		Low Acuity Community First Responder

Average response times for *all NWAS category 3 calls* [10] were compared to the response times for the category 3 calls which NWAS assigned to Low Acuity CFRs during the pilot project *. The key findings were:

- As shown in Chart 5, Low Acuity CFR response times have been consistently lower than average NWAS response times every month since the pilot began.
- Across the year to date, Low Acuity CFR response times have been on average 1 hour and 39 minutes (or 99 minutes) less.
- A further recognised performance measure for ambulance services is the 90th centile incident response time (time within which 9 of 10 patients were seen). The 90th centile figure for NWAS category 3 calls average response time was almost 457 minutes compared to Low Acuity-assigned CFR calls which was 216 minutes - lower by almost 240 minutes (4 hours).

These findings demonstrate that for category 3 calls the Low Acuity CFRs can help reduce the time patients need to wait for an initial response from NWAS. Further, the Low Acuity CFR service delivers response times for that are much closer to the NWAS general category 3 calls performance targets [11].

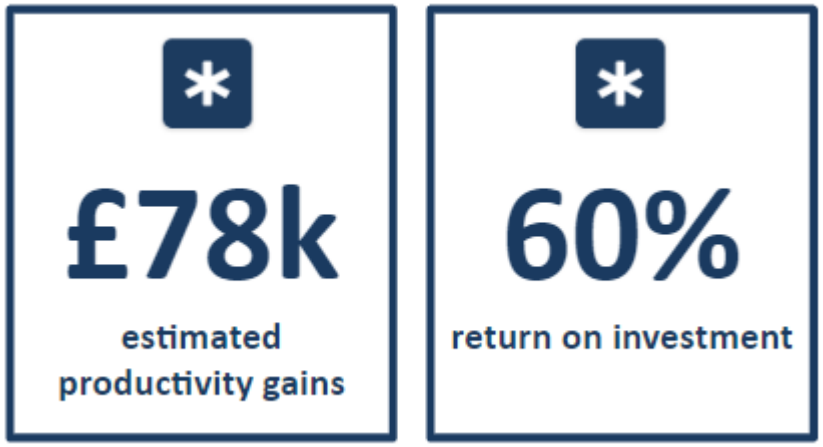
**Caveat: the NWAS category 3 response times are across all category 3 cases, whereas the Low Acuity CFR-assigned cases are a small, selective proportion of category 3 cases including non-complex cases.*

[10] *NWAS response times were sourced from NHS England published data: Ambulance Quality Indicators. At the time of writing, year-to-date data inclusive of October had not been published. Therefore, NWAS data pertains to April to September 2022.*

[11] *"The NWAS performance target for Category 3 patients is that 9 out of 10 patients will be seen within 120 minutes" – NWAS performance standards - 999*

Impact: on the ambulance service

Did the pilot project deliver any financial benefit for NWAS?



If ambulances were to have attended the Low Acuity CFR-assigned calls there would have been cost implications for the service…

- According to the National Schedule of NHS costs, the average cost for an ambulance service call out where the patient is 'seen, treated or referred' is £268.43 [12]. This cost would have been applicable for the 290 CFR calls that resulted in non-ambulance attendance. The estimated cost should an ambulance have attended is therefore **£77,845.47 in productivity gains**.
- A calculation was undertaken by the NWAS finance team to determine the costs of delivering the Low Acuity CFR role. Extrapolated to the evaluation period (April to October 2022) the cost is estimated to be is £48,548.50. This includes: the LAC staff costs; and CFR costs of mileage, training, uniform and non-pay contributions. *(NB this figure does not include the cost of recruiting, training and equipping new CFR volunteers as the volumes used in this scenario are based on the existing Low Acuity CFR volunteer pool)*
- We therefore estimate **a return of investment of 60%.**

[12] National Schedule of NHS costs - 2020/21, AMB tab. Calculations for estimated productivity gains and return on investment have been based on information provided by NWAS finance team.

Insights: the patient experience

What did we learn from the project in terms of patient outcomes and experience?

The improved response times (shown on the previous pages) will likely result in an improved patient experience. However, we do not at this stage (for Phase 1 of the evaluation) have any feedback from the patients to be able to validate this.

We were able to collect encouraging insights and example stories that suggest a broader evaluation could deliver evidence results in this area, as shown in the table below.

Insight	# calls	Example story
CFR visits can lead to calls being reassessed and their **priority raised**, which can make a significant difference to the clinical outcome and potentially save lives.	31	*Attended a patient with what was triaged as a minor illness (category 3 call). However, on arrival the CFR's assessment showed that the patient had an underlying heart issue with a very slow heart rate of just over 30 BPM. The call was escalated and a prioritised ambulance attendance to convey the patient was completed.*
Some CFR interventions mean patients did not end up unnecessarily in hospital and were instead provided with an alternative pathway such as going to the GP. **Given the current wait times for ambulances and ED, this would make a huge difference to the patient** - as well as to the ambulance service and the acute hospital.	51	*Many calls where patients have long waits for ambulance attendance following a fall on floor (non-injury). In cases where the patient had been on the floor for over an hour, they would need to have a mandatory hospital attendance. This was avoided in some of the cases where a local CFR was able to be deployed more quickly.*
CFRs are able to more easily manage many 'false alarm' situations such as accidental pendant alarm activations, especially in remote (non-urban settings). These types of calls waste a huge amount of ambulance time nationally each year, but also can be distressing for patients when they see an ambulance has been called	n/a	*Patient with pendant alarm activation. Careline was unable to contact patient or family which led to a category 3 call. CFR attended and found patient was fine, they had accidentally sat on pendant alarm. Patient was hard of hearing and was unable to respond to Careline's calls. If called out, an ambulance would have had a long distance to travel due to remote location, and ultimately wasn't required.*

Insights: the volunteer experience

What is the experience for CFR volunteers on the Low Acuity pilot project?

NB This case study is based on interviews with NWAS volunteers and has subsequently been anonymised. The image is taken from the NWAS website and used for illustrative purposes only.

"

After I retired, I enquired for volunteering opportunities at NWAS which is when I heard about the Low Acuity CFR volunteering role. I chose to volunteer as a CFR because **I wanted to help people in my community who might not have the support from their family or friends**. I have now been a qualified CFR for seven months and I have been spending three evenings each week volunteering as CFR.

Becoming a CFR was quite simple. I completed in-person training which was spread across multiple days, and I also had to complete some online training sessions. Once I became qualified, my journey as a volunteer began with my shadowing local CFRs to gain some practical experience of what I could expect whilst volunteering on scene. I then began attending scenes independently.

As a CFR, **I have flexibility in choosing the hours I would like to volunteer**. All the CFR volunteers have received a **pager to sign in whenever we would like receive a volunteering job** and then to sign off once we are done for the day. Once we sign on to the pager, the LAC is informed and then will start allocating us to patients who need to be attended to. Before we receive a patient to the pager, we first receive a phone call to tell us a bit about the patient's background, symptoms and location and then we are asked whether we feel comfortable attending to the patient. **Whilst on the scene are we always supported by clinicians** (LACs) from the EOC, they discuss symptoms with us and advise on questions we should be asking.

My whole CFR experience has been heartwarming. The support I provide **helps the patients to feel less anxious as well as reassures the patients' families that we are listening to their concerns**. The most enjoyable part of becoming a CFR is that you get to meet so many different people from your community and **make a difference**. Last week I attended to a patient who had a stroke. From their 999 call the symptoms they described did not seem like a stroke. However, once I was on the scene I was able to recognise that this was the case. Aware that time was precious I communicated this information back to the LAC so that an ambulance could get to the scene quicker. **This helped to treat the patient's symptoms much faster.**

My biggest frustration as a CFR is that I know that we can be doing more if we had more funding. It would be nice if some of the money which we have helped to save gets invested back into the low acuity project.

"

Insights: the staff experience

What is the experience of delivering the LAC role?

Four months ago, this clinician (LAC) role for the CFR service was advertised on our staff intranet. I chose to apply because I have been a paramedic for the last 30 years and I thought the skills I have gained would be beneficial when directing CFR volunteers at scene.

My main responsibility is to **make sure that the patient's journey is as smooth as possible**. I am able to do this by ensuring that **I choose the most suitable CFR volunteer** (in terms of their skill set and what they are comfortable in doing) to ensure that the patient's needs are met. **My duty of care for the volunteers is also a priority for me.**

I always aim to ensure that the volunteers feel comfortable and happy before allocating them to patients. I always try to have a **quick phone call to discuss the patient's history, needs, and the best course of action for the volunteer to undertake** whilst being on the scene. I also support both the patient and volunteer whilst they are on the scene. For example, if the volunteer believes that the patient's call category should be upgraded or downgraded I would take this into consideration to ensure they receive the right support. This could sometimes involve sending a taxi for the patient rather than waiting for an ambulance or even **referring to other sources of support such as the GP.**

I enjoy my role because I know that I am having a direct impact on the patient's experience. For example, I am aware that 80% of the time I am able to avoid an ambulance being called out because either the CFR has been able to deal with the patient on the scene, the patient has seeked support from an additional service, or they have found another way for the patient to get into hospital. Moreover, freeing up ambulance services also mean that the **patients who are in absolute need of an ambulance are getting one quicker**, which means more patients are happier. Another advantage of my role is knowing it is leading to a substantial return on investment for the NHS.

A challenge I face within my role, is that I know I am able to do more, but I am restricted due to CFR volunteers are unable to attend scenes of patients who have either: consumed alcohol, have mental health issues, suffering from trauma, under the age of 12. This results into the CFR volunteers only being able to support a limited number of cases.

NB This case study is based on interviews with NWAS staff and has subsequently been anonymised. The image is taken from the NWAS website and used for illustrative purposes only.

Limitations

Limitations of the pilot and CFR operations, provided by the NWAS evaluation team

- Although the data indicates an improved response times for incidents, it is worth noting CFR are a small, and important, part of the Trust that will not significantly affect the performance of the Trust owing to the scale of the operation.
- This is evident in the saved hours calculation; 469 hours saved over 61 pilot days is on average 54 hours per week; whereas in Cumbria & Lancashire (C&L), NWAS roster approx. 14,000 DCA (double-crewed ambulances) hours per week, i.e. saving 0.4%.
- CFRs cannot respond to all incidents. The report compares CFR responses against all presentations; further refinement is required to create a more accurate comparison.
- The CFR incidents in question are practically all in C&L. The report compares CFR response performance against all areas, however C&L has significantly better performance for lower acuity responses than trust wide data.
- NWAS, as with all ambulance trusts, is facing challenges in many areas of the business. Comparing performance in extraordinary periods will yield different results at different times. A baseline (we often use 2019 figures) may be more appropriate for any future evaluation.
- Rapid Response Vehicles (RRVs) with single person response may offer a similar service/saving.
- CFRs are a voluntary service, and do not have to respond. The response, or rate of response, per CFR will differ geographically based on many factors, making predicting national outcomes very difficult.

Helpforce acknowledge the limitations of the current rapid evaluation (Phase 1) and plan to address a number of these in a future evaluation (Phase 2).

Conclusion & Recommendations

What does this initial evaluation tell us, and what could happen next with the Low Acuity CFR project?

Conclusion

The findings of this rapid evaluation demonstrate significant impact for what is currently a pilot project. The data we assessed proves that the project is making a real difference to the ambulance service in terms of reduced ambulance callouts and response times.

The Low Acuity CFR role is an excellent example of where volunteering can make a vital difference to health services: a clinically-led, intelligently designed role, utilising a trained and motivated group of volunteers that know their local community - benefiting all involved.

This role has tremendous potential to make a difference to all ambulance services. However, there is a consistent message from all of the managers operating this role: it needs investment. Most crucially it needs a *team of dedicated LAC staff* that can provide 'wraparound 365 coverage'. By just having a single member of staff, or by using staff that do the LAC role alongside other commitments, means that the Low Acuity CFR offer is diluted and inconsistently applied.

For NWAS we have estimated how this small increase in cost could deliver high impact results and an exceptional return on investment, on the following page.

Recommendations

A call for investment

Given the pressures that ambulance services are under at this time, we recommend that immediate action is taken to embrace and fully implement the Low Acuity CFR role nationally.

Funding will be required for the ambulance trusts so that they can employ the required LAC staff to scale-up and operate this role to its full potential. And there will also be a need to invest further in volunteering infrastructure, to support volunteer management in the ambulance trusts with recruiting and training additional CFR volunteers. Although there are already a high number of CFR's operating across all ambulance trusts, many are already assigned to existing roles such as responding to cardiac arrests.

Further evaluation

Helpforce and NASRMG are planning a Phase 2 *Insight & Impact project* together, which would look to do a more comprehensive evaluation of the Low Acuity CFR role nationally. This will allow us to prove the broader benefits of this role, if the ambulance trusts involved are able to secure the funding needed to grow the pool of LAC staff and additional CFR volunteers.

Future potential: for NWAS

If fully implemented what value could the Low Acuity CFR role potentially deliver to NWAS?

We created the following range of scenarios based on the evidence within this document, and through discussions with the NWAS management team.

- *Low - 'pilot peak'*: 100 low acuity CFR-assigned call pcm - based on number of cases in October 2022 when the pilot project achieved highest volumes to date
- *Medium - '365 LAC capacity':* 238 low acuity CFR-assigned cases pcm - since the LAC was only available on 13/31 days of October 2022, in this scenario we assume the full 31 days are covered in a month
- *High - 'fully implemented': this assumes (1) creation of a 'LAC assistant' role (band 3) to help allocate out more cases; (2) LAC support window extended from 12 to 16 hours, 8am to midnight; (3) more CFRs recruited across all five regions of NWAS.*

Costs for the low & medium scenarios were provided by the NWAS finance team, with increased staff costs to provide multiple LAC staff to provide 'wraparound 365 coverage' and expenses for the existing Low Acuity CFR volunteer pool.

For the *High* scenario the higher annual cost covers the 'LAC assistant' role plus funding to recruit, train and mobilise additional Low Acuity CFR volunteers.

	Scenario:	*Low*	*Medium*	*High*
Activity	Low acuity CFR-assigned calls (pcm)	100	238	440
	Low acuity CFR-assigned calls (pa)	1,200	2,856	5,284
Impact	Non-ambulance attendance (pa) - *based on 77.3% non ambulance attendance rate (page 10)*	928	2,208	4,084
	Total ambulance time saved (mins, pa) - *using 99 mins average job cycle time (p.11)*	91,832	218,561	404,338
	Total ambulance time saved (hours, pa)	1,531	3,643	6,739
£	Cost to run Low Acuity CFR scheme (£, pa)	£99,332	£99,332	£139,829
	Productivity gains (£, pa) - *based on average cost of ambulance call out (p.13)*	£248,996	£592,610	£1,096,328
	Return on investment (pa)	113%	185%	416%

Future potential: for ambulance services England-wide

If implemented nationally what is the potential impact of the the Low Acuity CFR role for all ambulance services?

Based on England-level call data we can see that NWAS manages about 1/10th of category 3 calls nationally. [13]

Therefore, for the scenarios created here (right) we have simply multiplied the Low Acuity CFR-assigned calls for NWAS by a factor of 10, to provide an illustrative example of the impact that this role could have nationally (the 11 ambulance services in England only, not all 14 ambulance services across the UK).

Caveat: these scenarios have been crudely estimated and should be used accordingly. The range may be far wider in reality: on one hand it may be hard to deliver the Low Acuity CFR role where it is not yet in place at ambulance trusts; on the other hand, the scope of the calls that the Low Acuity CFR role covers could be broadened.

	Scenario	*Low*	*Medium*	*High*
Activity	Low acuity CFR-assigned calls (pcm)	1,000	2,380	4,403
	Low acuity CFR-assigned calls (pa)	12,000	28,560	52,836
Impact	Non-ambulance attendance (pa) *- based on 77.3% non ambulance attendance rate (p. 10)*	9,276	22,077	40,842
	Total ambulance time saved (hours, pa) *- using 99 mins average job cycle time (p.11)*	15,305	36,427	67,390

[13] *NWAS responded to 9.92% of all category 3 calls in England over the course of 2021-22 - NHS England - Ambulance Quality Indicators*

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- Ed Fulker, Lead analyst for NWAS, provided assurance on the data that was collected for this pilot and validated it against the live CAD data. Ed also provided the list of limitations listed on page 17.
- Helpforce was not commissioned directly to undertake this evaluation. We would like to clarify when, why and how we do evaluations like this one.
    - Helpforce is a charity on a mission to accelerate the growth and impact of volunteering in UK health and care.
    - As part of our work, we offer an evaluation solution to support organisations in health and care called the *Insight & Impact (I&I) Service.* This is a web-based service that aims to make evaluation more accessible and easier for those managing volunteers to demonstrate the impact that they make on health outcomes.
    - We typically do not charge for the I&I service – by default we offer it pro bono, using our existing donor funding to cover our I&I team costs
    - This enables Helpforce to select evaluation projects where we believe there is a high chance of demonstrating the difference that volunteers, and the voluntary sector, make on health and care. And we are most interested in working on projects like this (the NWAS Low-acuity role) where it shows the potential, if scaled, to positively impact the health and care system.
    - Our evaluation is completely independent of NWAS, NHS England and other organisations involved with the Low-acuity pilot project. Our evaluation findings are reviewed by the award-winning public services consultancy PPL.

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About Helpforce

Helpforce is a UK-based charity that works with organisations within health and care to accelerate the growth and impact of volunteering.

https://helpforce.community/iandi