Care Quality Commission

A fresh start for the regulation of ambulance services

Working together to change how we regulate ambulance services

The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles:

- We put people who use services at the centre of our work.
- We are independent, rigorous, fair and consistent.
- We have an open and accessible culture.
- We work in partnership across the health and social care system.
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote equality, diversity and human rights.

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Foreword from the Chief Executive

We have set out a new vision and direction for the Care Quality Commission (CQC) in our strategy for 2013-2016, *Raising standards, putting people first* and in our consultation, A new start, which proposed radical changes to the way we regulate health and social care services.

We developed these changes with extensive engagement with the public, our staff, providers and key organisations. Stakeholders in the care sectors have welcomed our proposals, which include the introduction of chief inspectors; expert inspection teams; ratings to help people choose care; a focus on highlighting good practice; and a commitment to listen better to the views and experiences of people who use services.

We recognise that there is much for us to do to strengthen how we regulate ambulance services. We need to better reflect the vital role this sector plays in ensuring patients get the right care, in the right place, at the right time, and the role it plays in the effective functioning of the wider health and social care system.

This document sets out our priorities for improving how CQC monitors, inspects and regulates ambulance services and, the conversations we want to have with all of our stakeholders in the ambulance sector, including our own staff, the public, providers, people who use services, their families and carers as we develop our new approach for this sector. . We also set out our intention to give greater priority to ambulance services and our initial thinking about how we will apply our model to this sector.

A new start set out the new overarching framework, principles and operating model that we will use; this includes the five key questions that we will ask of all services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive?
- Are they well-led?

We are clear, however, that we will recognise differences between the sectors and will develop and apply our model for each of them accordingly

The programme of work set out in this document is hugely important. It will help us to make sure that we deliver our purpose – to make sure services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. If we can achieve that we hope it will improve the lives and experiences of people who use ambulance services, their carers and families.

David Behan
Chief Executive

Introduction from the Chief Inspector of Hospitals

In my role as the Chief Inspector of Hospitals, I am responsible for overseeing the regulatory activity and assessments of quality of ambulance services, as well as acute hospital, community and mental health services.

The development and roll-out of our new approach is gathering pace. Last summer we started this journey by focusing on developing our model for NHS acute hospitals following this with adult social care, mental health services, community health services, GP practices and GP out-of-hours care. We are now looking at the approach for the ambulance sector, building on the things that we have found works well from other sectors.

Our future work will encompass ambulance services provided by NHS trusts, private providers or the voluntary sector.

Ambulances services care for patients with unscheduled health care needs (such as emergency 999 calls and urgent hospital admissions requested by GPs) as well as scheduled needs (transporting people to attend out-patient appointments and day care facilities). They play a major role in ensuring that patients receive the most appropriate care for their needs and that fewer patients are taken to A&E departments unnecessarily.

A unique characteristic of ambulance services is that they regularly work across a whole range of health and social care providers and wider public services. The ability of ambulance staff to work effectively, in an integrated manner to meet the needs of their patients is of paramount importance.

Where possible, we will align relevant elements of our ambulance services approach with other sectors and providers, including general practice, 111 and out-of-hours services.

We can only achieve our vision for ambulance services by genuinely engaging and working with those who work in and receive care from ambulance services. We look forward to doing so.

Sir Mike Richards
Chief Inspector of Hospitals

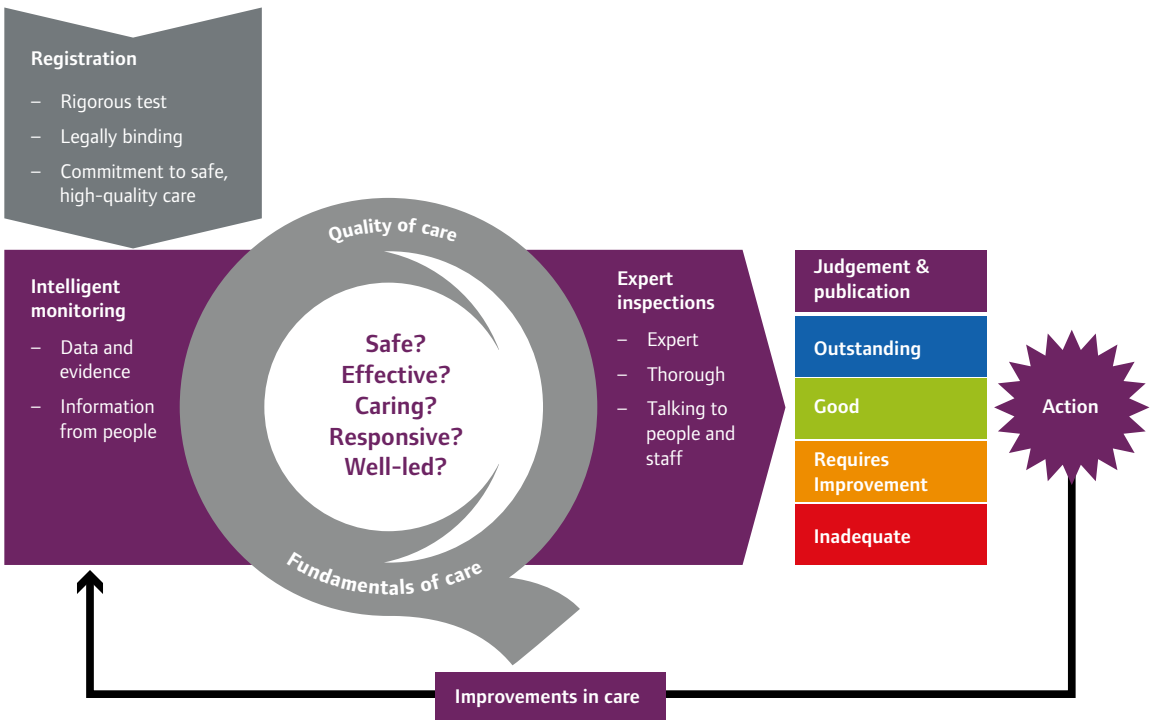
1. Monitoring, regulating and inspecting ambulance services

Our consultation A new start set out the principles that guide how CQC will inspect and regulate all care services. It described our future 'operating model' which includes:

- Registration with CQC to provide health and care services.
- Standards that those services have to meet.
- Better use of data, evidence and information to monitor services.
- Inspections carried out by specialists.
- Information for the public on our judgements about care quality, including a rating to help people compare services.
- Action to require providers to improve, making sure those responsible for poor care are held accountable for it.

These principles guide our regulation of ambulance services, but the detail of how we will do this will be specific to the sector and to the services that are provided within it.

FIGURE 1: OVERVIEW OF OUR FUTURE OPERATING MODEL



Asking the right questions about care

To get to the heart of people's experience of care, we need to make sure we ask the right questions about the quality of services, based on the things that matter to people. We will ask the following five questions of every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Simple, clear standards to help us judge the quality and safety of services

In the past, our approach has been to concentrate on a legal statement about whether or not a provider is complying with standards of quality and safety. In future we will go beyond statements of legal compliance, and tell people in clear and simple language what we think about the quality and safety of the care given by that provider.

> **"Over the next three years we will develop a ratings system for most providers of health and social care."**

We will make sure the public are clear about the safety and quality of care they can expect from their health and social care services. We will simplify our approach to reflect the five questions we will ask about the quality and safety of services.

Ratings to make clear the quality of care

Over the next three years we will develop a ratings system for most providers of health and social care. Our ratings will develop to become the single, authoritative assessment of the quality and safety provided by an organisation. They will be primarily based on the judgements of our inspectors about whether services are safe, effective, caring, responsive to people's needs and well-led, but will also take into account all the information we hold about a service and the findings of others. We will develop them with the public, partner organisations, providers of services, clinical and other experts.

Ambulance services that the Chief Inspector of Hospitals will be responsible for

The Chief Inspector of Hospitals' responsibilities cover all ambulance services, whether they are provided by NHS trusts, private providers or the voluntary or charitable sector.

NHS ambulance Trusts first came into scope for registration with CQC in April 2010. The remaining parts of the sector namely private, voluntary and charitable services came into scope in April 2011. This was the first time that independent ambulance services were subject to any formal regulation.

Main characteristics of ambulance services

Ambulance services are unique in that, compared to some other parts of the health and social care system, their staff regularly work across a range of other providers and professionals. For example during one ambulance shift staff may work alongside GP's, community nursing staff, care home workers, social care workers, midwives, police officers and fire service personnel. The ability of ambulance staff to work effectively, in an integrated manner to meet the needs of patients is of paramount importance

Ambulance providers supply a range of services for people of all ages. The majority of care is provided face to face, although services are increasingly able to deliver appropriate advice and help over the telephone. NHS and independent providers can both collaborate and compete with each other over all types of services. The exception to this is receiving and triaging 999 calls as this function is only carried out by the NHS.

Different types of provider

Ambulance providers vary immensely in terms of size and degree of activity. Each NHS ambulance services employs thousands of staff and operates hundreds of vehicles. An NHS trust can provide services for a number of clinical commissioning group areas and performance can vary between areas. Between them, NHS services will answer over 9million 999 calls this year. This contrasts sharply with some private ambulance services that operate just two or three vehicles and employ only a small number of staff to care for very few patients. Such variations will pose considerable challenges in terms of inspection team composition as well as comparability and consistency in our inspections in the future.

Across the sector, care is provided by a number of different roles at different grades. Registered healthcare professionals include paramedics, doctors and nurses and other professionals include ambulance technicians, emergency care assistants, call handlers and patient transport staff.

Main services

Not all providers will offer all of the services listed below, or some may only provide certain elements of a service.

- Receiving and triaging 999 calls and attending and treating life-threatening incidents.
- Providing appropriate responses, advice and treatment to non-life-threatening 999 calls.
- Undertaking specialist services requested by healthcare professionals, such as transfers (high dependency, intensive care transfer, paediatric, patients with mental health needs).
- Patient Transport Services (PTS).
- Response to major incidents.
- The provision of 111 services and GP out-of-hours services.

999 calls

Today the quality and standard of clinical care provided by ambulance services is very different to what it was just a decade or so ago. Furthermore ambulance services are developing their ability to assess and advise patients over the telephone without the need to dispatch an ambulance. Other patients can be assessed, treated and cared for at home thus avoiding unnecessary journeys to hospital. Ambulance clinicians can also support people to manage a range of conditions by assessing, treating and referring onto appropriate pathways without transporting the patient to A&E by either providing treatment in their home, or at by transporting the patient to an alternative healthcare setting. They can also treat some minor injuries at home. When patients do need emergency admission, the right assessment by the appropriate clinician or appropriately trained individual means that they are able to be taken to the right specialist unit to meet their needs, even when this is not the nearest hospital, whilst treatment and care continues during that journey.

Working in support of NHS ambulance services is a network of air ambulances funded by public charitable donations that has been established across England. Currently there is a network of 19 air ambulance charities that provide nearly 30 ambulance helicopters between them. NHS ambulance services are able to despatch these aircraft to transport a doctor and/or paramedic to the scene of an incident over greater distances or to remote areas. Often this is much quicker than could be achieved by a land ambulance. Sometimes a land response will arrive first with additional care being provided by the air response. Dependent upon the location and condition of each patient the air ambulance will either fly patients to hospital or care for patients until the arrival of a road ambulance.

Arrangements for the provision of the helicopter, pilot and clinical crew can vary between different charities. The majority of air ambulance services fall outside of the scope for CQC registration because the air operator (the provider of the aircraft) is regulated by the Civil Aviation Authority (CAA) and the staffing and governance of the service is a matter for the host ambulance service. However, in a small number of cases, where the clinical staffing and governance of the service is the responsibility of the private or voluntary provider, the provider requires registration with CQC.

Services requested by healthcare professionals

Healthcare professionals such as doctors, dentists or midwives can request an ambulance to provide "urgent" patient transport. GP's can request ambulance services to take patients to hospital within an agreed timeframe. Hospital based clinicians request vehicles to transfer patients between hospital sites. These can be high dependency or intensive care retrievals. For example, the organisation of neonatal care networks means that a new born baby may need to be transferred from one hospital to a neonatal unit in another hospital.

Although ambulance transport is normally provided only for people with a medical need there may be social factors such as availability of public transport that make the use of routine non-emergency ambulance transport necessary. Patient transport services (PTS) are provided by some NHS ambulance services as well as many providers in the independent sector.

Responding to major incidents

Ambulance Services have a key role in the response to major incidents such as train crashes, building collapses or incidents of a chemical, biological, radioactive, nuclear, or explosive nature. Each NHS ambulance service has a major incident plan that is practised regularly and integrates with similar plans of other emergency services, other parts of the health service such as acute hospitals, public utilities and the voluntary sector. All NHS ambulance staff are trained in Major Incident Response and each service has a dedicated group of staff additionally trained to respond to high risk incidents that present

additional risks and training requirements. These groups are known as the Hazardous Area Response Team (HART) and are able to access patients in challenging environments and undertake treatment more quickly than in a conventional response. NHS trusts have specific responsibilities under the Civil Contingencies Act 2004.

Dependent upon the reason that someone uses the ambulance service it may be a one off experience (for example as a result of an emergency call) or it may be a more regular experience (for example attending a regular outpatient appointment).

Patient transport services

Patient Transport Services (PTS) accounts for the vast majority of patient journeys. Services are regularly "market tested" by commissioners and it is common for private and sometimes voluntary ambulance services to be competing against NHS services to secure the contract for PTS services. At the same time during periods of high demand, NHS ambulance services have subcontracting arrangements with both the private and voluntary sector to provide additional staff and vehicles to meet the demand for emergency and urgent services.

There is no doubt that the role of the independent ambulance provider is changing and their proportion of the market is growing. In addition to their work with private hospitals and care homes it is estimated that 50% of all inter-hospital transfers are now undertaken by private ambulance providers. The private ambulance sector also includes companies that do not undertake PTS subcontracting work in the NHS. Instead these companies specialise in the provision of medical cover services for sporting and cultural events, festivals and other public gatherings where an ambulance service is needed. Only those that provide services that treat patients and take them to hospital are within the scope of CQC's registration and inspections. Those who provide care "on site" but do not transport to hospital are not subject to regulation.

Another example of where the independent service is able to specialise is the transportation of Mental Health patients. Patients should always be conveyed in a manner which is most likely to preserve their dignity and respect their rights whilst being consistent with managing any risk to their health and safety or to other people.

The pre-hospital aspect of ambulance care means that for some people the ambulance service may be their first contact with the NHS or its contractors in the care being provided. A person's care during the pre-hospital phase can promote early recovery and help contribute to a positive outcome for patients.

111 services and GP out-of-hours services

111 services are designed to make it easier for patients to access their local NHS healthcare services. Patients can call 111 when they need medical help fast but it is not a 999 emergency. Some ambulance providers also provide GP out-of-hours services. We are developing our methodology for inspecting both as part of our approach to primary care under the Chief Inspector of General Practice. However we will ensure that our approaches are aligned and will coordinate our inspection activities for a provider that provides both ambulance services and primary care services.

> **"Each NHS ambulance services employs thousands of staff and operates hundreds of vehicles."**

2. How we are developing the new regulatory approach

We are committed to developing how we monitor, inspect and regulate in partnership and we know we do not have all the answers. We have started our formal engagement through our advisory group and we will be using other routes to advise, update and seek views to shape the new model of regulating ambulances.

We are developing our new approach in four main strands, set out below.

1. What matters to patients.
2. Developing how we inspect ambulance services.
3. Developing our information to monitor providers.
4. Focusing on local partnership and integrated arrangements.

1. What matters to patients?

Applying the five questions to ambulance services

At the heart of our new approach is our commitment to tailor our inspections to the issues that matter in each sector. Under each of the questions we will consider the following issues.

- Are they **safe**? For example are medicines managed correctly, is equipment and fleet clean, safe, and well maintained, is there effective safeguarding, is there learning from incidents, are staff trained in safe practices, how are safe staffing levels assured?
- Are they **effective**? For example, are the right assessments carried out, is there correct diagnosis, is treatment effective, are services audited, is care evidence based and with best pathways followed with the right staff and mix of skills. How does the provider compare nationally against quality standards? How do all clinicians maintain the essential skills for effective care?
- Are they **caring**? For example are patients, families and friends treated with compassion, dignity and respect whatever the setting?
- Are they **responsive**? For example are responses timely, do they seek feedback from patients and carers, and share information appropriately about patients. What alternative routes do they use to gather feedback from groups such as frequent users of services, vulnerable patients, those with dementia, mental health patients, how do they change to meet variations in demand?

- Are they **well-led**? For example how do organisations covering large geographical areas ensure governance, appropriate culture and leadership. Conversely how do smaller providers with few permanent members of staff do so? Is there integration with other providers, learning from good practice, and forward planning and capability to respond to major incidents?

We will base our judgements on a range of services and will look across all geographical areas that services are provided from. We will pilot different ways of sampling care across areas in order to get beneath the service of the care provided across the organisation and get a true picture of how well-led the organisation is.

Ratings

Where there is enough information to allow ratings to be delivered, and where we think publishing ratings would drive improvement for patients, we will develop a rating system. The ratings that would be awarded are: outstanding, good, requires improvement and inadequate.

We will work with key stakeholders, including people who use services to describe what "good" looks like as we expect all organisations to be providing good care. They will be based on existing standards.

We will also agree at what level ratings are meaningful for patients and the public e.g. provider level, and or regional level, and or service level.

We will start introducing shadow ratings from October 2014.

Supporting good practice

When judging organisations we will look at whether they are exceeding national standards on a range of indicators and how they are collaborating with partner organisations across a health and social care economy. We will look for evidence of innovative approaches to improving outcomes, preventing inappropriate care and opportunistic interventions to tackle heath inequalities.

Where we find that services are not good, we will work with other bodies and organisations to ensure providers improve. We retain the ability to use our enforcement powers where appropriate.

2. Developing how we inspect ambulance services

We will be consistent in the way we regulate services and make judgements of services including those that provide care in dispersed teams across large geographical areas. Any variation in inspection approach will be based on the complexity and size of the organisation.

Involving patients and the public in our inspections

We will pilot different ways of getting feedback from people who use services. We want to understand the views of people who have experience of using the service. We recognise that this is a particular challenge in relation to patients who have received trauma care or care in another life threatening situation and often it is their family members and friends who are in the best position to share experiences and opinions. We also want to hear from people who have used or experienced the patient transport services, as well as hearing the expectations of people who may uses services in the future.

We will make sure people who use services and the wider public have the opportunity to tell us what they think of their ambulance services and we will directly contact those with experience of the service. We will also include experts by experience as members of the inspection team.

Expert inspection teams

Our inspections will be carried out by inspectors that understand the services they are inspecting. We will also use expert clinicians and professionals who work in the ambulance service in other parts of the country. We will only use experts to inspect services for which they have no conflicts of interest.

The size of the inspection team will reflect the size, complexity and activity of the service we are inspecting. Where there are specialist services, for example the triage technologies within the emergency operations centre, we will aim to ensure that our inspection team includes members with expertise in these areas. This will help to ensure the credibility of our new inspection regime for ambulance services.

Observing care

Ambulance services provide care in a range of different settings (for example in a public place, at a place of work, in a person's home, inside an ambulance or within a hospital). In order to make judgements about how safe, effective, caring, responsive and well-led care is we will have to make maximum use of methods that are available to observe care. We need to ensure that at all times our inspectors are inspecting appropriately and sensitively.

Core services

We will always inspect a core set of services where they are provided by an organisation (whether NHS or independent). These core services must be both relevant to the people who use the service and highlighted because of the potential risks and quality issues. A provider may not provide all aspects of a core service, and they will be judged on the elements that they do provide.

We welcome your feedback on our proposed four core services described below:

1. Responding to life threatening conditions and incidents

This covers all aspects of how the service responds to life threatening conditions and incidents. This includes how the control room receives and triages these calls. The speed of response as well as the quality of pre hospital clinical care provided can have a significant bearing on the outcome of life threatening calls.

Emergency 999 calls are triaged using approved prioritisation systems to determine the appropriate type and speed of response to meet the needs of the patient. All NHS ambulance services are currently required to achieve national performance standards for their speed of response to emergency calls.

The highest priority emergencies are known as Red (previously known as category A calls). These calls are categorised into sub sets known as Red 1 (calls that are immediately life threatening) such as cardiac or respiratory arrest and Red 2 (other life threatening calls that are not immediately so time critical such as Strokes and Fits). Red call patients are required to be reached within no more than 8 minutes (in at least 75% of all occasions) of the call being taken in the ambulance service emergency operations room although the "clock start" is earlier for Red 1 calls than for Red 2 calls. A high proportion of Red call responses will result in a patient being taken to an acute hospital (often known as "see and convey").

The type of response that is sent to a 999 call varies. It may be a single responder or volunteer community responder, with vehicles varying from cars, ambulances, bicycles, motorbikes and air ambulances. The level of clinical skills of the responder also varies from a volunteer with first aid training to a specialist paramedic with a range of additional skills

Whilst independent and voluntary providers will not receive or triage 999 calls directly they may be contracted by an NHS ambulance service to respond to Red calls. They may also transport patients suffering from a life threatening condition to hospital from events they are providing medical cover for. These will not have been prompted by a 999 call.

2. Responding to non-life threatening conditions and incidents

This covers all aspects of how the service responds to 999 calls which have been triaged as non-life threatening conditions and incidents. This will look at the how the control room has triaged calls as non-life threatening. Triage decisions may be to send an ambulance service clinician to assess the patient face to face (see and treat) or to

provide the caller with telephone advice either directly from the ambulance service call taker or by arranging for another care professional to call back within a pre-determined time frame (hear and treat).

The recommended response times to calls in this category are known as Green 1, 2, 3 and 4 standards and are agreed locally. Effective triage helps to ensure that patients receive the right care in the right place and avoids putting unnecessary burdens on A&E departments. Further enhancing urgent care services provided outside of hospital is a key aspect of the national agenda to transform urgent and emergency care services in England.

3. Services requested by healthcare professionals

Ambulance services are commissioned to care for patients who have had to contact a healthcare professional and who consequently need transporting to hospital because of clinical need or in some cases from one hospital to another, for example high dependency and intensive care transfers. Patients can often be elderly and/or highly dependent and may require clinical care and treatment on route.

Delivering urgent care services is a key component in the overall provision of unscheduled ambulance services. Meeting patients' needs before their conditions deteriorate and require a more immediate response is vital.

4. Patient Transport Services (PTS)

Every day thousands of people are taken by a PTS vehicle to such things as day hospitals and outpatient appointments. People that use these services have a variety of needs. Some are able to walk with minimal assistance and sit in the ambulance during the journey, others require carrying to the ambulance and others may require the use of a stretcher on route. The majority of these people will be reliant upon the quality of the PTS to get them to and from the care they need. In many instances people would require home care or hospitalisation if PTS services were not available to support them.

Groups with specific needs

Within these core services we propose to specifically follow the care of certain groups of people who have specific needs. We do not propose to individually rate the care provided to these groups but we will use this information to inform our judgements. The groups we are considering are:

- People with a long term condition.
- Bariatric users of services.
- Patients requiring end of life care.
- Patients who have fallen.
- Patients who have had a stroke.
- Patients who have had a cardiac arrest.

3. Developing our information to monitor providers

Where there is available data that provides answers to the five questions, we will seek to use it. We will make sure that we focus on using data that tells us about the effectiveness and quality of the care provided rather than data that overly focuses upon systems unless there is a strong reason to do so. We also want to strengthen the information we gather from people who use services, their families and staff who deliver the service. For many ambulance providers who do not have NHS contracts, there is a lack of data available. To overcome this we may have to collect this data from providers prior to, and in between onsite inspection activity.

4. Focusing on local partnerships and integrated arrangements

Ambulance services are an integral part of the wider health and social care system. They interact with hospitals, community, mental health, primary care and adult social care services. The quality of those partnerships has the potential to transform the experience of people who need "seamless

" health and social care, whether that is on an individual occasion or to meet an ongoing need.

Ambulances services play a key role in the clinical care pathway achieving positive outcomes for patients with particular needs such as stroke, cardiac or trauma care by maintaining partnerships within networks for these critical conditions. The development of patient pathways means that patients are able to be taken directly to a place of definitive care specific to their needs rather than incurring delay by being admitted via an Emergency department.

Often ambulance providers have multiple partnerships and arrangements with a number of different organisations that can vary within the different regions it provides care for. Our Chief Inspectors of Hospitals, General Practice and Adult Social Care will work together to look at how ambulance providers are working with partner organisations to develop alternative pathways to ensure patients get the most appropriate treatment as quickly and efficiently as possible. We will share information with and from all sectors to understand the quality and safety of ambulance services.

In our new approach to regulating ambulance services we recognise the impact of the commissioning of alternative models of health and social care on the ability of ambulance services to provide care that best meets the needs of patients, closer to home.

Where ambulance services are also contracting with other providers (for example to deliver PTS services for them) we may look at the quality of their contract management as part of our assessment of the well-led domain. When inspecting all providers we will always make judgements based on whether the service is safe, effective, caring, responsive and well-led. Where services are not good, we will comment on the factors that contributed to this.

Your feedback

We would like to hear any feedback you have about out suggested approach, but are particularly keen to hear about the following:

- How do we adapt our approach for providers that cover large geographical areas?
- How do we ensure consistency of our approach within the sector, between organisations of different complexities and size, and between the NHS and private providers?
- How should we present information for a provider with a large number of different locations?
- Do you agree with our intentions to strengthen the information we gather from people who use services, their families and staff who deliver the service and to collect information before and in between inspections from providers who do not have contracts with the NHS?
- Where should there be differences in how we apply our approach to different types of providers because of the risks and characteristics of particular providers?
- Do you agree with our proposal to specifically follow the care of groups of people with specific needs (page 13). If so, do you agree with our proposed groups?

Please contact us with any feedback or comments at: cqcinspectionchangesAMB@cqc.org.uk

3. What will happen next?

CQC is committed to developing changes to how we inspect and regulate in partnership with the ambulance sector, the public and with groups representing patients, families and carers.

We have set up an advisory group as one important way to engage with stakeholders. The group has met twice and will continue to support our work by providing expert advice, opinion, and challenge. In addition to this group, we will set up smaller task and finish groups to ensure experts from the sector and people who use services can contribute and help us to develop our assessment framework and inspection methodology.

We will be doing specific engagement around what methods we can use to ensure that we get meaningful feedback from people who use services and how we can most appropriately observe the quality of care.

Current proposed timeline

We will be developing our approach for ambulance services in consultation with our key stakeholders and the public to ensure we reflect the key characteristics, risks, quality issues and diversity of organisations that exists within this sector. We will refine and learn as we go to produce a meaningful system of inspections and we will provide ratings for those organisations where this will serve as a lever for improvement. The timeline for the development and implementation of our new approach is set out below.

April to June 2014

- Wide engagement with internal and external stakeholders.
- Ongoing meetings with our internal and external advisory groups.
- Development of inspection methodologies for piloting.

July to September 2014

- Begin testing our new inspection methodologies for the sector.
- Formal eight week consultation on new guidance for all providers on how to comply with the new regulations.

October to December 2014

- Carry out another set of inspections in order to refine our new inspection methodologies, including the assignment of shadow ratings where appropriate.
- Publish formal consultation on our proposals for ambulances.
- Publish shadow ratings.

January 2014

- Roll out of the new approach for ambulance services.

Although this is not a formal consultation, we would like to hear your views on any of the priorities and changes that we are proposing in this document:
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