## Statistical Note: Ambulance Quality Indicators (AQI)

* The latest Systems Indicators for August 2016 for Ambulance Services in England (where data were available2) showed the standards in the Handbook[[1]](#footnote-1) to the NHS constitution were not met.

## A. Systems Indicators

### A1 Emergency response in 8 minutes (Figure 1)

In August 2016, of Category[[2]](#footnote-2),[[3]](#footnote-3) A Red 1 calls in England, resulting in an emergency response, the proportion arriving within 8 minutes was 70.0%. It should be noted that data on Category A calls are only available for 8 of the 11 Ambulance Trusts2.

In August 2016, of Category2, 3 A Red 2 calls in England resulting in an emergency response, the proportion arriving within 8 minutes was 63.8%. It should be noted that data on Category A calls are only available for 8 of the 11 Ambulance Trusts2.



The standard for Ambulance Services is to send an emergency response, with a defibrillator, within 8 minutes to 75% of Category A calls. Figure 1 shows that for England, Red 1 performance increased to 70.0%[[4]](#footnote-4) in August 2016.

For Red 1, out of the eight trusts for which data is available none met the 75% standard. Five trusts had proportions of less than 70%: North East (68.1%), East of England (68.9%), London (68.7%), South East Coast (64.6%) and Isle of Wight (56.4%).

### A2 Dispatch on Disposition (DoD)

In January 2015, the Secretary of State for Health announced[[5]](#footnote-5) the introduction of Dispatch on Disposition (DoD), allowing up to two additional minutes for triage (to identify the clinical situation and take appropriate action). This was based upon clinical advice that it would be likely to improve the overall outcomes for ambulance patients.

For Red 1 calls, the clock start time is still the instant that the telephone call connects. However, from 10 February 2015, all other calls received by London Ambulance Service (LAS) and South Western Ambulance Service (SWAS) use DoD.

During October 2015, DoD was introduced in the Ambulance Services of North East (NEAS), Yorkshire (YAS), West Midlands (WMAS) and South Central (SCAS).

The differing clock start times mean that data for the different cohorts are not comparable with each other. Red 2 calls comprise the vast majority of Category A calls, so 19 minute Category A data are also not comparable.

Figure 2 shows the Red 2 measure for each cohort, where available.



The numerators and denominators for the above proportions are displayed in the Systems Indicators Time Series spreadsheet at <http://bit.ly/NHSAQI>, on the “DoD R2” tab, and the “DoD A19” tab shows equivalent figures for the 19 minute measure below.

### A3 Clinical Coding Review

As the next stage of the Ambulance Response Programme[[6]](#footnote-6), a clinically led evidence based review of the current call coding categorisations has been undertaken. The aim of this review is to re-categorise calls to focus on ensuring patients receive the most appropriate response. The existing Category A (Red 1 and Red 2), Green 1, Green 2, Green 3 and Green 4 categories will be replaced with new categories.

The new categorisations were initially being piloted in 2 Ambulance Trusts, introduced in South Western Ambulance Service and Yorkshire Ambulance Service on the 19th April 2016 and the 21st April 2016 respectively. West Midlands Ambulance Service also joined the pilot on 8th June 2016. With this introduction, data for the Red1, Red 2 and Category A measures will no longer be available for the Trusts involved from these dates. Partial data was therefore supplied for South Western Ambulance Service and Yorkshire Ambulance Service in April 2016 and for West Midlands Ambulance Service in June 2016.

It should be noted that the new call categorisations are not comparable with previous categorisations for the following reasons. The review has assessed all available disposition codes and for each re-assigned the code to a new group i.e. the new Red category does not contain the same code set as the old Red 1 or Red 2 category. In addition detailed changes have been made to the “clock stop” criteria, where appropriate.

### A4 Category A Ambulance response in 19 minutes (Figure 3)

The other ambulance standard in the Handbook to the NHS Constitution is for trusts to send, within 19 minutes, a fully-equipped ambulance vehicle, able to transport the patient in a clinically safe manner, to 95% of Category A calls. For England[[7]](#footnote-7), this measure increased to 91.3% in August 2016. The performance for trusts taking part in DoD but not part of the clinical coding review (North East and South Central) was 92.8%. The performance for trusts (North West, East Midlands, East of England, South East Coast and Isle of Wight) not undertaking DoD or taking part in the clincial coding review was 89.9%.



DoD does not affect how other indicators are measured, but it may lead to changes in the levels for other indicators. For example, a longer triage time may mean fewer ambulances dispatched, leading to better ambulance availability, and more timely responses to Red 1 calls. A longer triage time may also mean more calls are closed on the telephone. However, any such effects will be difficult to detect within the habitual variation of the many Ambulance Quality Indicators.

### A5 Systems Indicators: Ambulance volumes (Figure 4)

The number[[8]](#footnote-8) of emergency telephone calls presented to switchboard in August 2016 was 797,871, an average of 25.7 thousand per day. Figure 4 shows that month to month there is a fair amount of variation in call volume.

There were 567,234 emergency calls that received a face-to-face response from the ambulance service in August 2016, an average of 18.3 thousand per day.

There were 399,542 incidents with a patient transported to Type 1 or Type 2 A&E[[9]](#footnote-9) in August 2016, an average of 12.9 thousand per day.



### A6 Latest monthly data for other Systems Indicators, August 2016

| Indicator | England | Lowest Trust | Highest Trust |
| --- | --- | --- | --- |
| Calls abandoned before being answered | 1.2%  | Yorkshire | 0.2% | South East Coast | 3.4 % |
| Calls resolved through telephone assessment | 9.6% | West Midlands | 5.1% | East Midlands | 16.5% |
| Calls resolved without transport to Type 1 or Type 2 A&E | 38.7% | Yorkshire | 30.7% | South East Coast[[10]](#footnote-10) | 49.9% |
| Recontact rate following discharge by telephone advice | 6.6% | East Midlands | 2.6% | West Midlands | 13.5% |
| Recontact rate following face-to-face treatment at scene | 5.0% | Yorkshire | 1.3% | London | 8.5% |
| Incidents where a patient was transported | 399,542 | NorthEast10 | 18,843 | London | 65,167 |

Of calls that received a face-to-face response from the ambulance service, the proportion that managed without need for transport to Type 1 and Type 2 A&E in August 2016 was 38.7%. This is a significant improvement[[11]](#footnote-11) on the previous 12 months and the highest proportion ever recorded.

The proportion of calls resolved through telephone assessment was 9.6%, slightly lower than the 10.4% recorded in August 2015.

## B. Clinical Outcomes

No thresholds to denote “poor” care are set for Clinical Outcomes. Commissioners are expected to examine trends in these data, and work in collaboration with ambulance trusts to achieve sustained improvement in patient outcomes over time; but commissioners are not expected to use Clinical Outcomes to performance manage trusts, because there will be significant variations in the populations served.

### B1 Cardiac arrest: return of spontaneous circulation (ROSC)

Patients in cardiac arrest will typically have no pulse and will not be breathing. In May 2016, in England, resuscitation was commenced or continued by ambulance staff out-of-hospital for 2,298 such patients. Of these, 672 (29.2%) had ROSC, with a pulse, on arrival at hospital (Figure 5), above the England average for 2015-16 of 27.8%. The largest proportion in May 2016 was 40.8% for South Central. The smallest proportion reported was 21.3% for East Midlands10.

The Utstein group[[12]](#footnote-12) comprises patients who had resuscitation commenced or continued by the Ambulance Services, following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed, and the initial rhythm was Ventricular Fibrillation or Ventricular Tachycardia. The Utstein group therefore have a better chance of survival.

There were 304 such patients in England, in May 2016, of which 162 (53.3%) had ROSC on arrival at hospital (Figure 5), above the average for 2015-16 of 50.5%. The largest proportion in the May 2016 was reported in North West with 67.9% and the smallest was 40.7% in Yorkshire[[13]](#footnote-13).



### B2 Cardiac arrest: survival to discharge

The proportion of cardiac arrest patients in England discharged from hospital alive was 8.5% in May 2016 (Figure 6), slightly above the average for 2015-16 of 8.3%. The largest proportion in May 2016 was 12.4% for South Central; the smallest was 5.1% for East Midlands.

For the Utstein group, survival to discharge in May 2016 was 26.1%, lower than the average for 2015-16 of 26.9%. The largest proportion was 57.1% for North East; the smallest was 8.7% for East Midlands13.



### B3 ST-Elevation myocardial infarction

ST-segment elevation myocardial infarction (STEMI) is a type of heart attack, determined by an electrocardiogram (ECG) test. Early access to reperfusion, where blocked arteries are opened to re-establish blood flow, and other assessment and care interventions, are associated with reductions in STEMI mortality and morbidity.

996 STEMI patients received primary angioplasty in May 2016, in England. Of these 996 patients, 852 (85.5%) of them received it within 150 minutes of the call being connected to the ambulance service (Figure 7), below the average for 2015-16 of 87.0%. The largest proportion in May 2016 was 92.7% for North East and the smallest was 67.8% for South Western[[14]](#footnote-14).



In May 2016, of 1,490 patients with an acute STEMI in England, 1,196 (80.3%) received the appropriate care bundle[[15]](#footnote-15), above the average for 2015-16 of 78.6%. Yorkshire[[16]](#footnote-16) had the largest proportion with 91.7% and the smallest was South East Coast with 66.7%.

### B4 Stroke

The FAST procedure helps assess whether someone has suffered a stroke:

* **F**acial weakness: can the person smile? Has their mouth or eye drooped?
* **A**rm weakness: can the person raise both arms?
* **S**peech problems: can the person speak clearly and understand what you say?
* **T**ime to call 999 for an ambulance if you spot any one of these signs.

In May 2016, of 3,456 FAST positive patients in England, assessed face to face, and potentially eligible for stroke thrombolysis within agreed local guidelines, 1,911 (55.3%) arrived at hospitals with a hyperacute stroke unit within 60 minutes of an emergency call connecting to the ambulance service. The largest proportion for May 2016 was 67.0% for South East Coast16 and the smallest was 32.0% for South Western.

There were 7,496 stroke patients assessed face to face in May 2016 in England, and 7,344 (98.0%) received the appropriate care bundle, above the average for 2015-16 of 97.6%. The highest proportion was recorded in the North West16 with 99.8% of patients receiving the appropriate care bundle; the lowest was South East Coast with 95.7%.



## C. Further information on AQI

### C1 The AQI landing page and Quality Statement

[www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators](http://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators), or <http://bit.ly/NHSAQI>, is the AQI landing page, and it holds:

* a Quality Statement for these statistics, which includes information on relevance, accuracy, timeliness, coherence, and user engagement;
* the specification guidance document for those who supply the data;
* timetables for data collection and publication;
* text files and time series spreadsheets containing all data from April 2011 up to the latest month;
* links to individual web pages for each financial year.

The web pages for each financial year hold:

* separate spreadsheets of each month’s data;
* this Statistical Note, and equivalent versions from previous months;
* the list of people with pre-release access to the data.

Publication dates are also at [www.gov.uk/government/statistics/announcements](http://www.gov.uk/government/statistics/announcements).

### C2 Revisions Timetable

Revisions usually follow a six-monthly cycle. The dates for past and future AQI scheduled revisions are below. The AQI Quality Statement above contains a more detailed revisions policy.

| Publication date |  | Series revised  |  | Months affected |
| --- | --- | --- | --- | --- |
| 10 November 20168 September 201612 May 2016 |  | Systems IndicatorsClinical OutcomesSystems Indicators |  | April 2016 to August 2016April 2015 to April 2016April 2015 to February 2016 |
| 10 April 2016 |  | Clinical Outcomes |  | April 2015 to September 2015 |
| 10 September 2015 |  | Clinical Outcomes |  | April 2014 to March 2015 |
| 4 June 2015 |  | Systems Indicators |  | April 2014 to February 2015 |
| 30 April 2015 |  | Systems Indicators |  | April 2014 to February 2015 |
| 5 March 2015 |  | Clinical Outcomes |  | April 2014 to September 2014 |
| 6 November 2014 |  | Systems Indicators |  | April 2013 to August 2014 |
| 5 September 2014 |  | Clinical Outcomes |  | April 2013 to March 2014 |
| 2 May 2014 |  | Systems Indicators |  | April 2013 to February 2014 |
| 7 March 2014 |  | Clinical Outcomes |  | April 2013 to September 2013 |
| 1 November 2013 |  | Systems Indicators |  | April 2013 to August 2013 |
| 2 August 2013 |  | Clinical Outcomes |  | April 2012 to March 2013 |
| 3 May 2013 |  | Systems Indicators |  | April 2012 to March 2013 |
| 1 February 2013 |  | Clinical Outcomes |  | April 2012 to August 2012 |
| 11 January 2013 |  | Systems Indicators |  | April 2011 to October 2012 |
| 31 August 2012 |  | Clinical Outcomes |  | April 2011 to March 2012 |

### C3 AQI Scope

The AQI include calls made by dialling either the usual UK-wide number 999 or its international equivalent 112.

As described in the specification guidance in section C1, calls made to NHS 111 are not included in the AQI measures for calls abandoned, re-contacts, frequent callers, time to answer calls and calls resolved by telephone advice.

All other Systems Indicators involve the dispatch of an ambulance, and include ambulances dispatched as a result of a call to NHS 111, as well as 999 or 112.

### C4 Related statistics in England

The AQI appear in a Clinical Dashboard, available from the AQI landing page, the websites of the Ambulance Trusts (listed in the AQI Quality Statement), and <http://aace.org.uk/national-performance/national-clinical-dashboards>. One of the aims of these Dashboards is to use statistical process control, to indicate whether variation in proportions reflects underlying change, or merely natural variance, unavoidable even when a health system is performing well.

The AQI are also used in the “Ambulance Services” publication by the Health and Social Care Information Centre (HSCIC), which includes additional annual analysis and commentary. Until April 2013, the HSCIC publication used the KA34 data collection, which was similar to the AQI Systems Indicators, but annual rather than monthly. After that date, the HSCIC publication used AQI data. [www.hscic.gov.uk/article/2021/Website-Search?q=ambulance+-accident&sort=Title](http://www.hscic.gov.uk/article/2021/Website-Search?q=ambulance+-accident&sort=Title)

Ambulance handover delays of over 30 minutes at each Emergency Department were collected and published by NHS England each winter until 2014-15: [www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps](http://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps)

The AQI Quality Statement described in section C1 contains more information on the HSCIC publication. It also contains details of weekly ambulance situation reports that NHS England collected for six months from November 2010.

### C5 Rest of United Kingdom

Ambulance statistics for other countries of the UK can be found at the following websites. The AQI Quality Statement described in section C1 contains more information about the comparability of these statistics.

|  |  |
| --- | --- |
| Wales: | <http://wales.gov.uk/statistics-and-research/ambulance-services/?lang=en> |
| Scotland: | See Quality Improvement Indicators (QII) documents at [www.scottishambulance.com/TheService/BoardPapers.aspx](http://www.scottishambulance.com/TheService/BoardPapers.aspx) |
| Northern Ireland: | [www.dhsspsni.gov.uk/index/statistics/hospital/emergency-care/ambulance-statistics.htm](http://www.dhsspsni.gov.uk/index/statistics/hospital/emergency-care/ambulance-statistics.htm) |

### C6 Contact information

For press enquiries, please contact the NHS England press office on 0113 825 0958 or nhsengland.media@nhs.net.

The person responsible for producing this publication is:

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### C7 National Statistics

The UK Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

* meet identified user needs;
* are well explained and readily accessible;
* are produced according to sound methods; and
* are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

1. Page 34 of the July 2015 Handbook to the NHS Constitution has Ambulance response time standards, [www.gov.uk/government/publications/the-nhs-constitution-for-england](http://www.gov.uk/government/publications/the-nhs-constitution-for-england). [↑](#footnote-ref-1)
2. Due to the introduction of Clinical Coding Review data for South Western Ambulance Service, Yorkshire Ambulance Service and West Midlands Ambulance Service are only available up to and including the 18th April 2016, 20th April 2016 and 7th June 2016 respectively. [↑](#footnote-ref-2)
3. On 1 July 2012, Category A (immediately life-threatening) calls was split into Red 1 and Red 2. Red 1 calls are the most time critical, and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 calls are serious, but less immediately time critical, and cover conditions such as stroke and fits. [www.gov.uk/government/news/changes-to-ambulance-response-time-categories](http://www.gov.uk/government/news/changes-to-ambulance-response-time-categories)

Due to the differences in clock start definitions for Red 1 and Red 2 it is not possible to aggregate them into a single proportion for Category A against the 8 minute standard. [↑](#footnote-ref-3)
4. See footnotes 2 and 3 on Page 1 [↑](#footnote-ref-4)
5. Dispatch on Disposition announcement: [www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2015-01-16/HCWS201](http://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2015-01-16/HCWS201) [↑](#footnote-ref-5)
6. Further information on the Ambulance Response Programme is available from the NHS England Website <https://www.england.nhs.uk/ourwork/qual-clin-lead/arp/> [↑](#footnote-ref-6)
7. See footnote 3 on page 1 [↑](#footnote-ref-7)
8. The number of emergency calls presented to switchboard does not usually include calls made to NHS 111 requiring an ambulance. 111 calls requiring an ambulance are usually transferred electronically direct to ambulance dispatch, and not routed via 999 call handlers. Occasionally, manual requests for ambulance are made between 111 and 999 call handlers, and such calls are included in the number of emergency calls presented to switchboard. [↑](#footnote-ref-8)
9. Type 1 are consultant-led 24 hour emergency departments with full resuscitation facilities.

Type 2 offer a consultant-led speciality A&E service such as ophthalmology or dental.

Type 3 is A&E / minor injury activity that may be doctor-led or nurse-led.

Type 4 are NHS walk-in centres. ([www.datadictionary.nhs.uk/data\_dictionary/attributes/a/acc/](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/accident_and_emergency_department_type_de.asp)
[accident\_and\_emergency\_department\_type\_de.asp](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/accident_and_emergency_department_type_de.asp)) [↑](#footnote-ref-9)
10. Due to its small size, performance on Isle of Wight tends to vary more than other trusts. If it has the largest or smallest value, the Table in A6 shows the second largest or smallest value, but has a footnote marker to show that Isle of Wight is more extreme. The Clinical Outcomes in section B also uses this system. [↑](#footnote-ref-10)
11. Significance calculations used are t test [↑](#footnote-ref-11)
12. This definition was proposed at Utstein Abbey in Norway by an international group of cardiologists and other health professionals in 1990. <http://circ.ahajournals.org/content/84/2/960.citation> [↑](#footnote-ref-12)
13. Excluding Isle of Wight. See footnote 10 on page 6 [↑](#footnote-ref-13)
14. Excluding Isle of Wight. See footnote 10 on page 6 [↑](#footnote-ref-14)
15. Pages 27 to 30 of the specification guidance for data suppliers on the AQI landing page at [www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators](http://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators) describe the care bundles, and certain exclusions, for the STEMI and stroke indicators. [↑](#footnote-ref-15)
16. Excluding Isle of Wight. See footnote 10 on page 6 [↑](#footnote-ref-16)