

Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
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London
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15th January 2015

Dear Secretary of State,

Clinical review of ambulance responses in England: Advice to Secretary of State

The ambulance service is a core component of the NHS in England; trusted to provide a swift and professional response to sudden illness and injury at any time of the day or night. In recent years demand has risen steadily, exceeding that of A&E attendances and hospital admissions.

The current time-based ambulance response standards have been effective in driving improvements, and maintaining response times to the most critically ill and injured patients. However, efforts to comply with these standards in the face of steadily rising demand over time have led to a range of operational behaviours that appear increasingly inefficient, and which have the potential to create a system with unnecessarily high and unevenly distributed clinical risk. Widely recognised examples of this problem include:

- Dispatching resources to a 999 call, on blue lights and sirens, before it has been determined what the problem is, and whether an ambulance is actually required.
- Dispatching multiple ambulance vehicles to the same patient, on blue lights and sirens, and then standing down the vehicles least likely to arrive first.
- Diverting ambulance vehicles from one call to another repeatedly, so that ambulance clinicians are chasing time standards rather than focussing on patients care needs.
- Using a “fast response unit” (car, motorbike, etc.) to “stop the clock”, when this unit may provide little clinical value to the patient (e.g. stroke victim), who then has to wait a long time for a conveying ambulance to arrive.

- Very long waits for lower priority (“green”) calls that nevertheless need assessment and conveyance to hospital, and some of which have time dependent problems.

I am obviously aware of the broader pressures the ambulance service has been under for some time and as you know NHS England has been actively considering these as part of the Urgent and Emergency Care Review since last year. I support the decision taken then to consider these long standing issues in that wider review. However, in light of the unprecedented increase in demand for ambulance services in the last two months, you asked me to consider whether there were any changes which could be brought forward quickly in order to help ambulance services maintain, and perhaps even improve, clinical outcomes for patients. It goes without saying that the proposals we have considered have been generated by clinicians and were motivated solely by a desire to reduce overall clinical risk in the ambulance system and improve the quality of care (effectiveness, safety, experience) for patients, their relatives and carers.

Firstly, we considered a review of Red 2 codes. The majority of patients currently coded as Red 2 do not ultimately derive clinical benefit from the arrival of an ambulance resource within 8 minutes, as opposed to the 19 minutes set out in the A19 standard. However, attempts to comply with the 8 minute standard lead to the operational inefficiencies described previously, and detract from the response to other patients. However, this would require an expert and patient working group be formed to take evidence, review existing data and reach consensus as to which (if any) of the current Red 2 codes could be moved safely to a specific A19 response rather than a non-specific 8 minute response. The conclusions of this group would need to be piloted in representative ambulance trusts, using both NHS Pathways and AMPDS systems, focussing on clinical outcomes, dispatch behaviour and operational efficiency. Whilst we believe that there is merit in this proposal and it should be considered further, I do not think this could deliver certain benefit in the short term. Patient safety is paramount.

Secondly, we considered a revision to the definition of the A19 standard to a “conveyance response”. The current technical definition of the A19 standard states that the vehicle arriving within 19 minutes should “be capable” of transporting the patient. This has been interpreted, in some instances, such that an ambulance fast response car can “stop the clock” because, in theory, it could transport the patient. However in reality the patient has to wait for an ambulance. Changing this definition would require a full and detailed assessment of the likely clinical and operational impact of amending the technical guidance to the vehicle “that transports” rather than “is capable of transporting”. A shadow “new A19” reporting system would then need to be established promptly so local ambulance trusts could determine their current dispatch behaviour and overall performance. Following this, ambulance trusts would have to be supported to implement dispatch behaviours that achieve more specific deployments (clinical and vehicle), with associated changes to their vehicle fleet. Whilst we believe this proposal should be considered further, once again I do not think this could deliver

benefit in the short term and ambulance fleet changes will take time.

Finally, we considered a proposal to allow an additional 1 to 120 seconds to the maximum “clock start” for all 999 calls except Red 1, where the clock start remains time zero. This proposal provides additional time to assess a call, in order to determine the best response, and where necessary send a single vehicle rather than several. It has already also been shown in a pilot in the South Western Ambulance Service (SWASFT) to increase the rate of “hear and treat” and decrease ambulance utilisation. This is the best developed and tested of the proposals, and already has broad clinical support as well as positive data. This early evidence and other analyses clearly show much potential, and I therefore recommend we proceed rapidly with two pilots, which can test the evidence more robustly. In these pilot sites, importantly a small number of potentially life-threatening codes must also be moved from Red 2 to Red 1 to ensure clinical safety and an even more rapid response to these conditions. We believe that this change would reduce the operational inefficiencies outlined above, whilst focussing on clinical need to maintain a very rapid response to the most seriously ill patients, particularly cardiac arrest. This would improve the chances of survival of these patients. It is anticipated that the overall outcomes of patients contacting the 999 ambulance service would be improved with reduced, and more evenly distributed and proportionate, clinical risk. We would test these expectations through a full evaluation at both pilot sites, and if conclusively proven, Ministers would want to implement this change throughout England.

If you agree with my recommendation, during the pilot period we propose that ambulance standards for all other areas will not be changed. We will continue to publish national data as normal, and the pilot data will be published alongside this in the interests of transparency. Given the pilots will only be affecting two ambulance services for a very limited period of time at the end of the reporting year, we would not anticipate that this will have a significant impact on the overall national data.

I hope this advice is helpful and I am happy to discuss the basis of my clinical opinion further with you.

Yours sincerely

A handwritten signature in black ink, appearing to read 'K Willett', with a long horizontal flourish extending to the right.

Professor Keith Willett
Director of Acute Care
NHS England