Gateway Number: 06141

NHS England
Medical Directorate
5th Floor (5W52)
Quarry House
Quarry Hill
Leeds LS2 7UE

Philip Dunne MP
By email and hard copy

11th October 2016

Dear Minister

Re: Ambulance Response Programme Clinical Coding Trial

I am writing to update you on the Ambulance Response Programme clinical coding trial underway in South Western Ambulance Service Foundation Trust, West Midlands Ambulance Service Foundation Trust and Yorkshire Ambulance Service.

Early results from the trial sites have shown a substantial reduction in the proportion of calls requiring an 8 minute (Red) response (6-8%) when compared to the previous Red 1 and Red 2 proportion of 50% or more. The group of "Amber" calls, however, has posed considerable operational challenges as these comprise a large proportion of calls in the new code set (around 70%), and rather than any response the correct response is now needed, for example a conveying vehicle, in order to "stop the clock".

The clinical coding subgroup has reviewed the call categories in order to address these issues using a number of fundamental assumptions:

- The underlying premise used for the initial call category review that response should be based on clinical urgency and the type of response required still holds true.
- The current assignment of call codes (AMPDS or NHS Pathways SG/SD combination) to the Red category is correct and does not need further review.
- The current assignment of call codes to the Amber categories does not discriminate sufficiently between calls for emergency conditions and those for urgent conditions which could wait longer for a response.
- The current separation of Amber calls into 3 categories based on need for treatment and transport, transport or face to face assessment is too complex and could be improved by a simpler transport or assessment split.
- There are some calls where a less urgent response (for assessment and onward management decisions) would be appropriate.
- To be successful the right balance has to be found between call volumes within categories and the associated time targets and operational capability and capacity.

Taking these factors into account the subgroup revisited the call category definitions and recommends a set of revised categories that will better reflect the response required for different types of conditions. These revised categories are set out in Appendix A, and have been approved by NASMeD, the National Association of Ambulance Services Medical Directors and ECPAG, the Emergency Call Prioritisation Advisory Group.

We plan to integrate this revised code set into the trial sites from 11th October 2016.

The trial will continue to be monitored and evaluated by our academic partner at Sheffield University's School of Health and Related Research as well as by the full governance structure of the ARP.

As we have discussed a full evaluation report has been commissioned. This was originally scheduled for Autumn 2016, however given the changes described above, and the time required to test these effectively, the report is now scheduled to be delivered at the end of February 2017.

Yours sincerely,

Professor Jonathan Benger, MD FRCS DA DCH DipIMC FCEM
National Clinical Director for Urgent Care, NHS England

Gateway Number: 06141

Appendix 1: Ambulance Response Programme Revised Clinical Coding set

Call Type Definition	Response and Resource
Category 1 -Life-threatening Time critical life-threatening event needing immediate intervention and/or resuscitation e.g. cardiac or respiratory arrest; airway obstruction; ineffective breathing; unconscious with abnormal or noisy breathing; hanging. Mortality rates high; a difference of one minute in response time is likely to affect outcome and there is evidence to support the fastest response.	**C1** Defibrillator Person trained to use defibrillator Ambulance clinician who can assess and deliver advanced life support Transporting vehicle where transport required Operational response plan to deliver fastest suitable resource
Category 2 - Emergency Potentially serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport. Mortality rates are lower; there is evidence to support early dispatch. **(For calls that need conveying clock stop is by the vehicle that actually conveys)**	**C2T** Assess; Treat; Transport e.g. Probable MI, serious injury, stroke, sepsis, major burns Suitably qualified clinician who can assess and treat **and** vehicle that does transport
	C2R Assess; Treat e.g. Fits; unconscious with normal breathing Nearest available resource (any type) with suitably qualified clinician who can assess and treat
Category 3 – Urgent Urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe. Mortality rates are very low or zero; there is evidence to support alternative pathways of care. **(For calls that need conveying clock stop is by the vehicle that actually conveys)**	**C3T** Assess; Treat; Transport e.g. serious injury modalities without systemic compromise; burns (not major); non-emergency late pregnancy/childbirth problems.
	C3R Assess; Treat Calls within scope of advanced clinical practice and suitable for treat and leave. e.g. uncomplicated diabetic hyper/hypoglycaemia; not immediately at risk drug overdoses; non-emergency injuries; abdominal pain.
Category 4 – non-urgent Problems that are not urgent but need assessment (face to face or telephone) and possibly transport within a clinically appropriate timeframe.	**C4T** Assess; Treat; Transport • 999 or 111 calls that may require a face to face ambulance clinician assessment • Requests for transport by health care professionals
	C4H Non-ambulance response Calls that do not require an ambulance response but do require onward referral or attendance of non-ambulance provider in line with locally agreed plans or dispositions, or can be closed with advice (Hear & Treat)
Type S – Specialist response Incidents requiring specialist response i.e. hazardous materials; specialist rescue; mass casualty	**Locally agreed plans apply**