To:
- Integrated care boards – chief executive officers
- Ambulance service – chief executive officers
- Acute trusts – chief executive officers
- 111 providers – chief executive officers

cc.
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 December 2024

Dear colleagues,

Winter 2024: Additional guidance for managing ambulance pressures

NHS ambulance services in England continue to experience significant pressure this winter due to high demand across the whole urgent and emergency care pathway and increases in hospital handover delays.

To maintain the resilience of ambulance services during periods of peak pressure, and to ensure that ambulance response resources are protected for the sickest patients, NHS England has worked with ambulance services to develop the following additional guidance in relation to:

- a revised approach to category 2 segmentation
- identification of category 5 patients overnight
- implementation of ‘call before convey’

The additional guidance recognises that not all patients contacting the ambulance service will receive the best outcome through a face-to-face ambulance response and conveyance to an emergency department; and that non-emergency patients are likely to achieve a better outcome and improved patient experience through access to urgent community response services, particularly where hospital pressures are such that patients will potentially be delayed awaiting ambulance handover.

This guidance complements mechanisms already available to ambulance services managing clinical risk and safety through escalation and demand management plans – including but not limited to 'W45' rapid release of ambulances delayed at hospital.

Ambulance services must continue to follow internal clinical governance processes while implementing these principles, and to work as partners to support the management of risk across organisations appropriately.

Revised approach to category 2 segmentation

In December 2022, NHS England rolled out an approach to segmenting category 2 (C2) ambulance calls through additional clinical oversight in emergency operation centres (EOCs) to prioritise the sickest patients. This was supported by the publication of the Delivery plan for recovering urgent and emergency care services.

C2 segmentation comprises rapid clinical navigation of those patients identified as not requiring immediate ambulance dispatch, and clinical validation of those patients who may be suitable for an alternative disposition following clinical assessment, to free up more ambulance resource for the most acutely unwell patients.

All ambulance services in England are live with C2 segmentation. However, from implementation in 2022 to the latest published data, a significant proportion of all eligible calls received an ambulance dispatch prior to clinical navigation taking place, and a sizable number of calls were also dispatched prior to clinical validation.

This guidance sets out a revised approach to C2 segmentation for all ambulance services as follows:

1. Calls are protected from dispatch for up to 5 minutes from coding (T5) to allow review by a clinical navigator and assess their eligibility for clinical validation.
2. Calls navigated for clinical validation are transferred into the clinical queue and protected from dispatch for a further 10 minutes.
3. If the additional 10 minutes elapses (15 minutes total from T5), the call will automatically return to the dispatch stack at its original position in the priority ordering.
4. Calls returned to the dispatch stack are still eligible for clinical navigation and validation up to the point at which the incident is dispatched.

The revised approach balances the priority of patient safety for all incidents that require a C2 ambulance response alongside the opportunity to increase the proportion of calls that are clinically navigated and validated before dispatch occurs. This will enable more patients to safely receive care without the need for a face-to-face response.

Risk mitigation

When ambulance response times are not compromised by winter pressures, there is a risk that some C2 patients identified as requiring an ambulance response will encounter a slight delay in dispatch while being clinically navigated and validated.

This risk is mitigated by excluding the sickest patients from C2 Segmentation (for example, stroke), and with periodic review of the remaining patients awaiting clinical validation as per standing operating procedures.

In all cases, where clinical validation and navigation has not occurred within 15 minutes from coding, calls are automatically returned to the dispatch queue in priority order.

Ambulance services will continue to be supported by the NHS England National Ambulance team at england.ambulance@nhs.net to ensure operational, clinical, technical and behavioural readiness for implementation of the revised approach.

Identification of Category 5 patients overnight

In some cases, to avoid unnecessary ambulance dispatch and conveyance, it may be clinically appropriate to support non-emergency patients presenting to the ambulance service overnight, to remain in their homes with sufficient clinical oversight, so that they can be booked into an urgent appointment the following morning (with, for example, same day emergency care, an urgent treatment centre, their GP).

Actions for the ambulance service:

1. Patients contacting the ambulance service out of hours (for example, between 10pm and 8am) who do not require an ambulance response, but do require an urgent care service or pathway that is not available at the time of the call, may receive a category 5 response and be held for referral.
2. A patient should not be held for referral under these principles where the alternative pathway does not re-open within an appropriate timeframe (maximum of 24 hours based on clinical assessment), or where there is a vulnerability or safeguarding concern.
3. The relevant alternative service required by the patient should be recorded by the clinician, and the held call marked as ‘not for dispatch’. These calls should remain visible on the clinical stack to ensure appropriate referral occurs immediately when services re-open.
4. During the call, the patient or their carer should be informed by the ambulance service that when the relevant service re-opens, they will be referred at this point. Following referral, the call can be closed, and the incident reported as a hear and treat outcome.

5. The responsibility for informing the patient and making the onwards referral arrangements should be clear and locally determined, and may include follow-up actions being undertaken by a nominated local service or the ambulance service.
6. Prior to ending the initial call, the patient or their carer should receive standard worsening instructions to call back if they deteriorate.
7. If the referral is rejected by the alternative provider, or the patient or their carer re-contacts 999, a new incident must be generated and undergo full re-triage and coded accordingly, with patients being kept informed of any changes to their outcome. The original call can be cancelled as duplicate in accordance with standard arrangements.

Actions for 111 providers:

1. Where a 111/clinical assessment service (CAS) can directly refer patients for an alternative urgent community response, they must continue to do so, including booking patients into services the following day.
2. Where 111 refers a call to the ambulance service that is appropriate for category 5, provision is underway to inform 111/CAS providers to transfer patients as a category 3 patient, but with a clear indication that they can receive a category 5 response as per these arrangements.

Actions for integrated care boards (ICBs) and regions:

1. Lead commissioning ICBs should make provisions to review senior clinical capacity available to ambulance service emergency operations centres (EOCs) overnight and consider rapid deployment of additional clinical capacity into EOCs through periods of peak pressure.
2. ICBs and urgent care providers must ensure that sufficient capacity is protected within urgent community services to enable direct booking for category 5 patients as soon as they open.
3. ICBs must agree a plan to support the appropriate and timely transport of category 5 patients to urgent community services (for example, patient transport services (PTS) or taxi) if they are unable to make their own way. Ambulance resource should not be used for non-emergencies.

Implementing ‘call before convey’

To improve patient experience and minimise long hospital handover delays, lead commissioning ICBs and ambulance services are asked to rapidly collaborate to confirm and agree ‘call before convey’ pathways for those patients who are likely to receive a better outcome without conveyance to an emergency department.

Call before convey protocols must be determined locally, with the purpose of supporting ambulance clinicians to avoid unnecessary conveyance to hospital, managing clinical risk in community settings, and signposting to alternative urgent community services.

Effective call before convey pathways relate to defined patient cohorts – for example, care home residents – and are reliant on good access to alternative community services and senior medical decision making.

Examples of call before convey models include, but are not limited to, call access to clinicians in the ambulance service emergency operations centre, a single point of access, a mental health crisis team, an emergency department consultant or primary care or local alternative.

ICBs and ambulance trusts must ensure there is sufficient clinical advice capacity to support call before convey throughout the 24-hour period, 7 days a week.

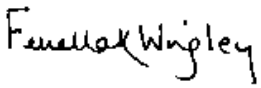
Overall ambulance job cycle times should be monitored to ensure that implementation of call before convey does not excessively delay ambulance clinicians seeking to provide patients with an appropriate community alternative or adversely impact on ambulance response times.

Yours sincerely,

Professor Julian Redhead

National Clinical Director for Integrated Urgent and Emergency Care

NHS England



Fenella Wrigley

Medical Advisor (Ambulance)

NHS England

Leaf Mobbs

National Programme Director for Urgent and Emergency Care

NHS England