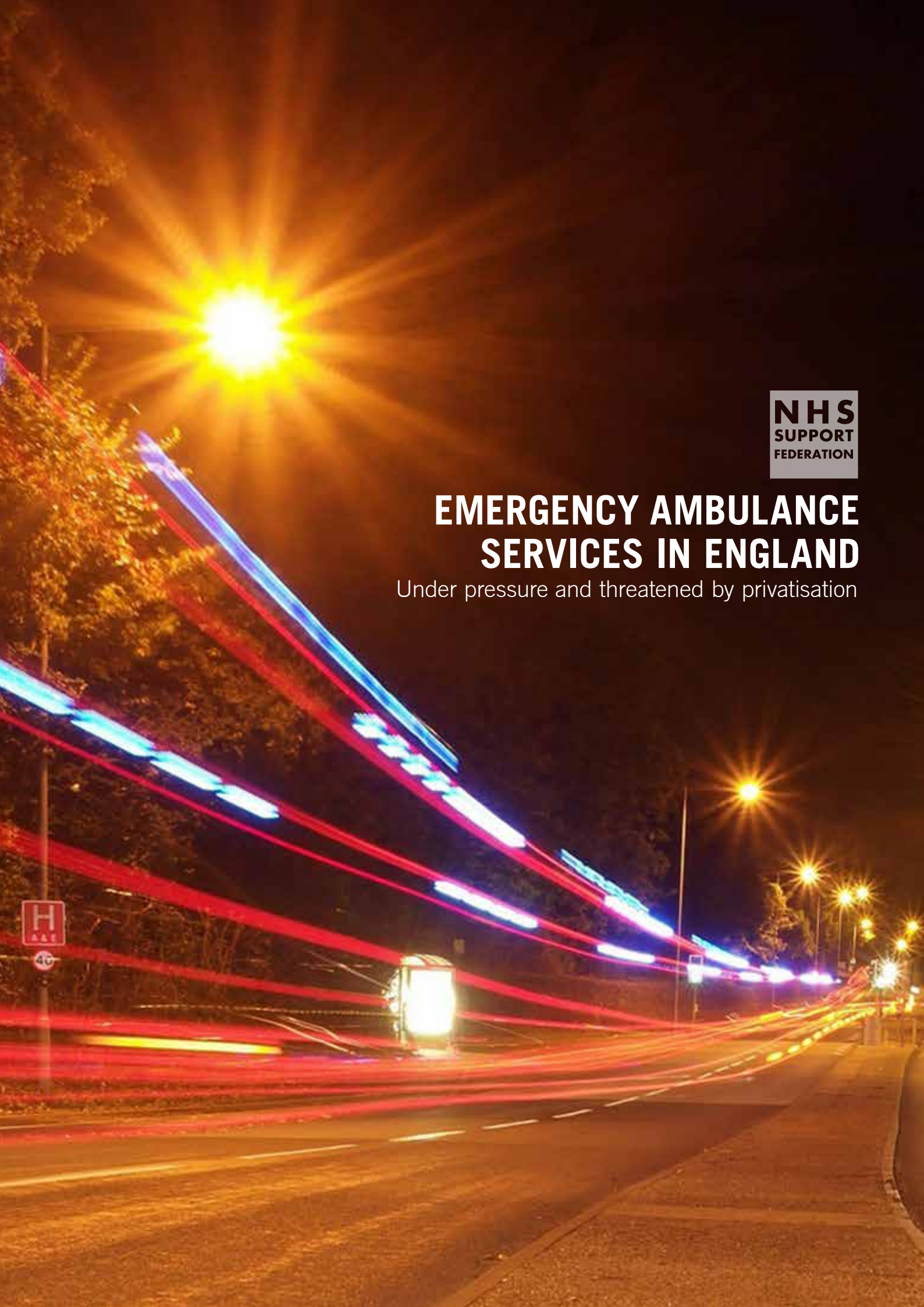


NHS SUPPORT FEDERATION

EMERGENCY AMBULANCE SERVICES IN ENGLAND

Under pressure and threatened by privatisation

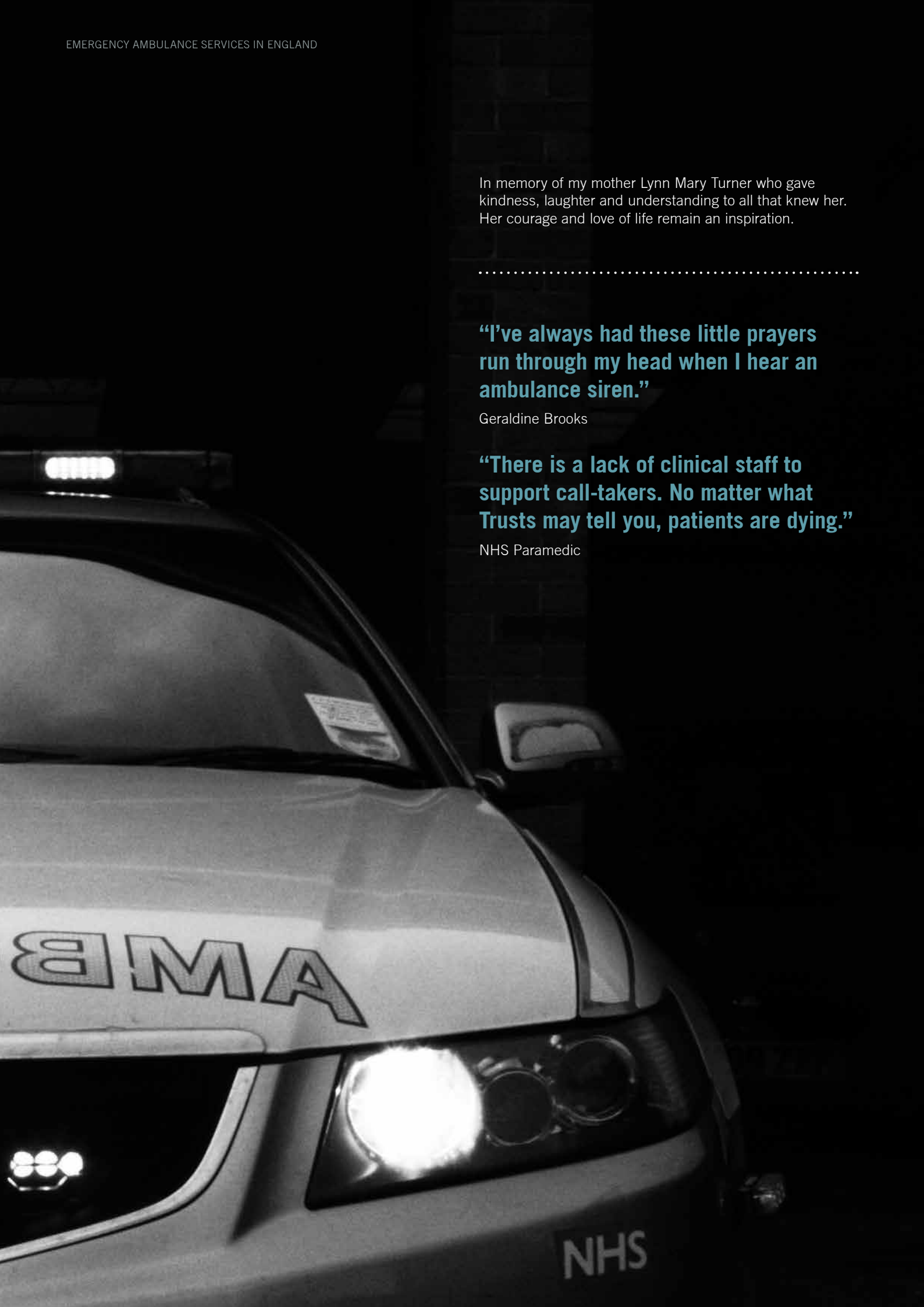
In memory of my mother Lynn Mary Turner who gave kindness, laughter and understanding to all that knew her. Her courage and love of life remain an inspiration.

"I've always had these little prayers run through my head when I hear an ambulance siren."

Geraldine Brooks

"There is a lack of clinical staff to support call-takers. No matter what Trusts may tell you, patients are dying."

NHS Paramedic



Contents

List of abbreviations used throughout this report

A&E	Accident and Emergency
ECA	Emergency Care Assistant
ECSW	Emergency Care Support Worker
EMT	Emergency Medical Technician
EOC	Emergency Operations Centre
CCG	Clinical Commissioning Group
CCP	Critical Care Paramedic
CFR	Community First Responder
COPD	Chronic Obstructive Pulmonary Disease
FOI	Request under the Freedom of Information Act (2000)
VAS	Voluntary Ambulance Service (such as St John's Ambulance or the Red Cross)
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
MND	Motor Neurone Disease
PP	Paramedic Practitioner
PTS	Patient Transport
SI/SIRI	Serious Incident Requiring Investigation

List of abbreviations for NHS ambulance trusts

EEAST	East of England Ambulance Service Trust
EMAS	East Midlands Ambulance Service Trust
LAS	London Ambulance Service Trust
NEAS	North East Ambulance Service Foundation Trust
NWAS	North West Ambulance Service Trust
SCAS	South Central Ambulance Service Foundation Trust
SECAmb	South East Coast Ambulance Service Foundation Trust
SWAST	South West Ambulance Service Foundation Trust
WMAS	West Midlands Ambulance Service Foundation Trust
YAS	Yorkshire Ambulance Service Trust

Executive Summary

Rising pressures

The demand for ambulance services has been rising by more than 5% for many years. In 2014-15 the number of calls to ambulance switchboards was 9 million, a 6.1% increase on the year before. Of these, 6.5 million received a face-to-face response and 3.1 million were classified as category A (most urgent). The number of seriously ill patients now take up half of all face-to-face emergency calls – compared with 27% in 2001.

Since 2010/11 the ambulance service has been finding £75million a year in efficiency savings (National Audit Office). In response trusts have imposed budget cuts, kept vacant posts unfilled, reduced training and cut staff. Ambulance resources are also being stretched because of cuts elsewhere in the health and social care system. Ambulance crews cope with shortcomings in mental health services and in the care of the elderly. They travel further because of closed hospital units and are regularly left to wait with sick patients outside of overloaded A&E units.

Using the private sector for blue light calls

The use of non-NHS ambulance providers has risen substantially. Our study found that they are now being used by all ten ambulance trusts in England to attend the most life threatening of incidents. Non-NHS ambulances responded to 139,086 life-threatening emergencies and 313,661 emergencies between January 2014 and March 2015. Private providers accounted for 89% and voluntary crews 11% of non-NHS attendances in our study.

There is wide variation in the use of non-NHS providers; from 17% use by South Central to less than 1% use by the West Midlands Ambulance Service. A survey of ambulance staff for this report revealed that many NHS staff are worried about the standard of care provided by some of these non-NHS crews. NHS managers told us that independent providers use less paramedics – the most qualified ambulance staff. An examination of trust board minutes found that managers have expressed concern about the spending on private ambulances. A large number of non-NHS providers are providing care to NHS patients, often in life threatening situations and yet their performance is not being systematically monitored.

Threats to patient care from understaffing

It is widely acknowledged that there are insufficient numbers of paramedics. Our research found that training budgets have been cut between 2012 and 2014. Overall numbers of paramedic posts have risen, but there are also a large number of unfilled vacant posts. Numbers are not high enough to keep pace with prolonged rises in demand. There is strong evidence to suggest that ensuring that there is a state-registered professional on every ambulance would increase patient safety and efficiency.

The effects of understaffing can be seen in the response to a survey of ambulance workers carried out by Unite the union. 53% of staff said that their individual workload had increased considerably from 2013-2014. 28% said that the increased workload is having a negative impact on patient care.

This survey also revealed examples of problems with the quality of care, near misses on patient safety and feelings amongst staff of high stress and excessive workload. They reported a shortage of paramedics and an increasing reliance upon staff that are less well trained.

The need to meet response times, cope with rising demand and insufficient paramedics is leading to underqualified staff being sent to handle emergency calls. This is both inefficient – as more qualified back up is often needed – and a threat to patient safety.

Declining performance statistics

Performance data from NHS England shows a decline in response times over the last 12 months. The average response time was below target for the most serious cases (Category A) throughout 2014 and the first quarter of 2015, reaching a new low over the winter period, although the Category A target (arriving to calls 8 within minutes in 75% of cases) was met in the April and May 2015.

There are large disparities in survival rates across the country. The trust with the lowest survival until discharge rate, is three times poorer in performance than the trust with highest.

In 2013/14 the number of complaints about ambulance services rose by 28%, the number of complaints about ambulance services rose by 28%, over five times more than in the NHS as a whole (5%). The number of serious incidents is rising and has doubled in two trusts in the last three years.

Problems hidden from public view

Despite the obvious pressures on the ambulance service many of the current problems remain unseen. This is because according to figures released to us by ambulance trusts around half (51%) of all emergency or “blue light” calls are not part of the performance monitoring statistics (response time and key quality measures). These can include patients with conditions such as suspected stroke, diabetes or limb fractures. This means that both positive and negative aspects of performance for nearly half of patients are not recorded.

Foreword

Many people consider a responsive and highly trained ambulance service to be essential in enabling the NHS to care for people at their most vulnerable. Although we take the service for granted, it was not until after 1952 that ambulances became re-organised to provide treatment.[1] It has taken decades to develop a framework to ensure consistent standards of training nationwide. There is now evidence that many of these gains are being threatened and there is increasing uncertainty about the quality of care that people will receive when they call 999.

Why I began this research

My research into the state of our ambulance services was prompted by personal loss. In 2013, my mother – who was suffering with Motor Neurone Disease – collapsed at home. Whilst in the care of an NHS ambulance crew from the South East Ambulance Service (SECAmb), she suffered a respiratory arrest and died two days later. My family had profound concerns about the standard of treatment that she received: I now believe that a crucial deficit in her care was the absence of a fully-trained paramedic onboard the first ambulance to attend.

At the outset, I sought to establish whether all ambulance crews were sufficiently well trained to safely deal with all types of emergency that they may encounter. Perhaps like many other members of the public, I had assumed that all ambulance staff were paramedics. In the course of this research, I learned that while this is not the case, senior figures within the ambulance service agree that there should be such state-registered professionals on every ambulance. I found that despite this, in order to cope with rising demand, trusts are increasingly relying on strategies that may reduce the likelihood of patients receiving a paramedic response. These practices, including the use of private providers, may be seen as a worrying indicator of a crisis within the service. This study begins by assessing what key performance indicators suggest about the scale of the problem of under-capacity.

Methodology

A combination of quantitative and qualitative methods were used. Using the Freedom of Information Act (2000), in February 2014 I asked ambulance trusts about staffing numbers, funding for training and the training levels of ambulance crews sent to the most serious emergencies. I also requested information about the numbers of private ambulances used to respond to specific categories of emergency calls. This was repeated in 2015. This detailed attendance data has made it possible to examine how non-NHS ambulance use is distributed over the various call categories, including those relating to the most serious emergencies. It has also made it possible to determine how well non-NHS ambulance use is monitored in NHS England statistics.

The call categories that are used were introduced into the ambulance service in June 2012. This study therefore, examines attendance data from that date until March 2014 when Trusts' responded to the above Freedom of Information (FOI) requests. This was followed up with second batch of FOI requests covering January 2014 to April 2015.

In order to place the information that was obtained from FOI requests within the context of ambulance service performance, NHS England system and quality indicators data from 2012-2015 were collated and analysed. We examined the growing demand on the service and how well Trusts have performed against response-time standards and on clinical quality measures.

The report examines the ten NHS ambulance trusts of England. It does not include the ambulance services in the Isle of Wight which are governed by different arrangements from those on the mainland.2,3 Eight trusts reported data in February 2014 and two (LAS and SCAs) reported to March 2014. Data was supplied by seven trusts in answer to Further FOIs from January 2014 to April 2015. Three trusts, LAS, NWAS and YAS supplied it to March 2015.

All numerical data was collated and analysed using IBM SPSS 22 and Microsoft Excel software. Qualitative data has come from a number of journal and press articles.

In order to go beyond the statistics and gain a real sense of sense of the problems that the data revealed, I consulted Unite's regular survey and communications with its members across the health service. In conjunction with the NHS Support Federation, Unite conducted a bespoke sample survey of ambulance members resulting in 162 individual responses. This provided a rare opportunity to gather ambulance crews' direct experience of the increasing pressures within the service. The survey was conducted using Questback online survey software.

In order to include ambulance workers' comments within this report, it was necessary to remove details that could identify any individual or case. There is however, one specific example of inadequate patient care that I am able to describe – that which originally indicated the need to conduct this research. I have decided to include details of my discussions and correspondence with senior members of SECAmb concerning my mother's care because of their bearing upon crucial issues within the ambulance service as a whole. In the latter regard, I have also spoken at length or corresponded with a number of senior figures within the Trust's management.

Nick Turner
Researcher, NHS Support Federation

1. Seeing the size of the problem

The figures published by NHS England are the only publicly available overview of how well the ambulance service is performing. They provide measures of how quickly trusts are responding to calls and limited statistics about patient outcomes. But how well does this data actually reflect the experience of ambulance staff and their patients?

We looked at the workload of all the ambulance trusts in England and how it is categorised. We then compared this with the activity figures from NHS England. This analysis revealed that many aspects of current performance are not publicly reported. This is because a large proportion of emergency calls are not part of the national quality monitoring statistics.

1.1 Why are emergency calls missing from the performance data?

Ambulance trusts divide up their emergency calls into different categories.[4] The most urgent of these are classified as Category-A. From June 2012,[i] Category-A calls were subdivided into Red-1 (most urgent) and Red-2 (serious but less time critical):[5]

Red-1 calls include patients with cardiac arrest who are not breathing and have no pulse or patients with an airway obstruction;

Red-2 calls include conditions such as stroke and fits.

Ambulance trusts are required to reach Category-A calls and provide life support within 8 minutes in 75% of cases – the 'A8' response standard. A second response target, specifies that trusts should be able to provide transport to Category-A patients, within 19 minutes in 95% of cases. The Category-A calls (Red 1 and 2) account for 49% of emergency calls reported to us by trusts.[6] This is shown in Figure 1.

Over half of all emergency calls have no required time response and have no clinical information recorded about them by NHS England

In addition to category A there are many other serious, but less urgent emergency (blue light) calls. These are categorised as Green-1 (serious clinical need) and Green-2 (less serious clinical need):

Green-1 emergencies can include suspected stroke (without serious symptoms) or diabetic problems;

Green-2 calls can include suspected limb fractures.

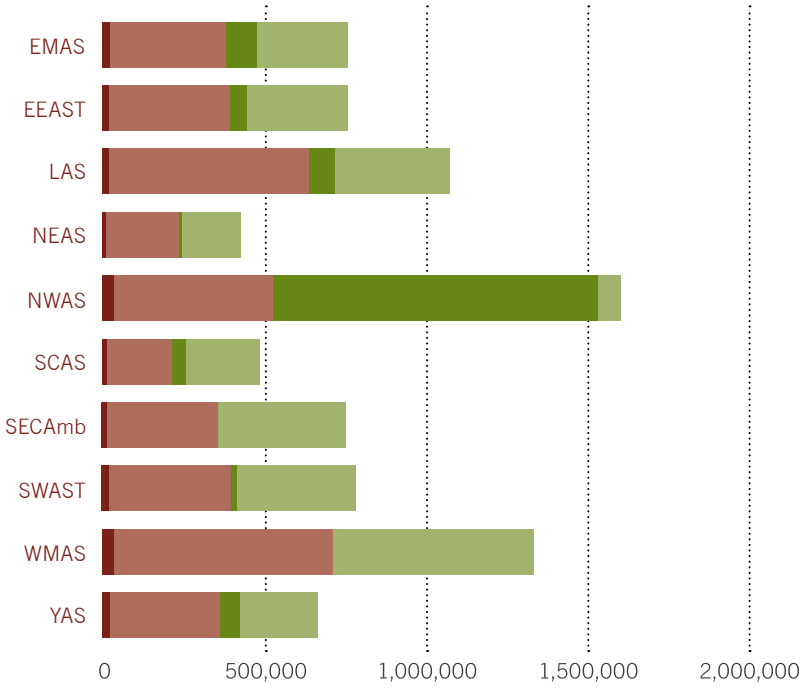
These Green calls are classified as emergencies and include conditions that may present greater risk if allowed to deteriorate. Despite their importance and urgency Green 1 and 2 categories have only recommended response targets. They also do not appear in the key national performance statistics.[7]

i Data before and after June 2012 are not strictly comparable. For this reason, we have chosen within this report to concentrate on the period from June 2012 onwards

Figure 1
Number of emergency calls broken down by category
January 2014 – April 2015*

Red-1 calls
Red-2 calls
Green-1 calls
Green-2 calls

Not all trusts consistently recognise all green categories. Some trusts do not use Green 1 (SECAmb, NEAS), while YAS use an additional unnumbered Green category.



*January 2014 – March 2015 for LAS, NWAS and YAS

An analysis of this data shows that Green-1 calls made up nearly 16% of all emergency calls and Green-2 calls accounted for just over 35%.[8] (Fig 1) Whilst together, these Green categories comprise 51% of reported emergency ambulance calls, they do not appear in national clinical outcome statistics.[9]

Concern about a lack of essential monitoring information was expressed in the 2011 Department of Health document, Transforming NHS Ambulance Services:

> **"The ability to improve performance is limited by a lack of data on patient outcomes ... Being able to assess the impact of delays ... and the accuracy of paramedics' diagnoses could help services to measure the safety and quality of patient pathways, and ensure that these pathways are tightly managed. But at present, data on clinical outcomes are available for only a few key conditions such as stroke and cardiovascular disease."** [10]

An over emphasis on response times has been criticized by the Department of Health as it creates:

> **"...a narrow view of what constitutes 'good' performance, and skewed the ambulance services' approach to performance measurement and management."** [11]

Performance measures were reduced in 2011 to cover only category-A calls. However other quality measures that can be viewed and understood by the public have not been introduced.

Mark Docherty, Director of LAS Commissioning in North West London, believes there is a case for broadening the scope of performance monitoring.

> **"In relation to the Green calls, I think the response times are not adequately monitored and this causes a few issues: they are locally determined and performance managed, so this can result in differing experiences depending where in the country you are. With Green 1 and 2 (particularly), these can involve patients that are well, but may be deteriorating rapidly, so this category can hide some patients who need a quick response."** [12]

2. Rising pressure: signs and causes

2.1 Growing demand from 999 calls

An analysis of the national statistics shows that there has been a prolonged period of growth in the demand for ambulance services.[13] According to a report from the Association of Ambulance Chief Executives (AACE) in 2011-12, the average increase in emergency calls was 5.1% over 2010-11. There is also wide variation in demand between areas. During 2011-12, some areas experienced increases of as much as 11.6%.[14]

In 2014 the Health and Social Care Information Centre (HSCIC) said that "the demand for ambulance services is generally increasing with a national 3.9% increase in emergency calls." [15] They add that "any increase in the number of emergency calls places considerable pressure on resources."[16]

Between 2012 and 2014 ambulance trusts received over twenty-five million calls;[17] in 2014-15 trusts received an average of 24,661 calls per day[18]

The number of calls to seriously ill patients rose by 5% in 2013. Based upon data obtained from NHS England,[19] HSCIC state that these calls occupy almost half of face to face emergency calls – compared with 27% in 2001.[20] The results of our own study in April 2015 confirmed these proportions. However NHS England do not measure the relative size of call categories and state that:

> **"There is no indicator explicitly designed to measure the split between Category A and Category-C [the latter includes Green 1&2] but some of the indicators can help with estimating this."** [21]

In contrast, our study uses specific data supplied to us by trusts about the number of Red-1 to Green-2 calls that trusts responded to. This shows that between January 2014-April 2015, Category-A calls comprised 49% of emergency calls.[22]

Media reports of ambulance pressures

The ambulance service warned that it is struggling to cope with the number of 999 calls and this has been widely reflected in media coverage. In 2014, the West Midlands Ambulance Service reported the following:

> **"Over the three days, Friday to Sunday, June 27 to 29, the Trust dealt with 7,889 incidents, which was almost six per cent up on last year. That is equivalent to over 145 incidents a day more than 2013."** [23]

In the same month The Express reported the experience of cardiac and elderly patients in London forced to endure long waits: "NHS horror: Heart-attack victims forced to wait four hours for ambulances." [24]

"Strained ambulance service to cut call-outs by 15%," revealed the Health Service Journal, describing how the London Ambulance Service Trust has announced that it will cut the number of emergency calls that receive an ambulance response by 15 per cent, in response to staff shortages and rising demand.[25]

In September the Guardian reported the experience of a grandmother who died whilst waiting in a queue of ambulances outside a busy hospital in Wales. Her family are critcal of the part this delay played in her death and highlighted the level of resourcing:

> **"We blame the cutbacks in the health service that has resulted in all of our ambulances having to wait."** [26]

The Oxford Mail reported that rural areas had been hit by a drop in ambulance response times: "Representatives from South Central Ambulance Service (SCAS) said there had been a significant rise in the past year in "red calls" and that it was using some private ambulances to help meet demand." [27]

In August 2014 it was reported that the number of patients in the East Midlands waiting more than an hour and a half for an ambulance "has more than tripled in recent months." [28]

The BBC has reported on the challenge presented to health services by a population that is living longer with more long-term disease.[29]

Some health commentators believe that too many patients are being treated in hospitals – particularly those with chronic conditions – and could be better cared for in the community. However budget cuts have seen the closure of such facilities. The BBC reported in November 2013 that the regulator Monitor had warned that the pressure on A&Es would rise as a result of fifty of England's walk-in centres being closed in the last three years.[30]

The demands on the ambulance clearly rise as other a parts of the health service come under pressure. The Daily Mail reported in November that emergency re-admission rates are rising and that this could be due to patients being discharged from hospital too early.[31] It has also been widely reported that patients in some areas who have been unable to get help through the non-emergency 111 system were calling on ambulance services for help instead.[32]

2.2 Funding pressures

Whilst demand for ambulance services has been rising finances have become tighter. From 2010 to 2014 the ambulance service has been forced to find around £75 million a year in efficiency savings – 4% of its budget,[33] as part of an initiative to improve productivity across the NHS. In addition the NHS has been restricted to inflation only increases in funding.

A number of ambulance trusts have announced budget cuts. East Midlands Ambulance Service has agreed to a £6.2million reduction.[34] Savings are being found by launching community ambulance stations, cutting management and reducing fleet operating costs. They deny that the changes will affect services. However similar plans to shed £14million from the budget in the North West brought threats for strike action. NWAS planned to reduce night cover, remove vehicles and reduce overtime. Staff in the area warned of a direct impact on services "from cuts in frontline services." [35]

Pressure from cuts in health and social care

In 2011 Liberal Democrat health minister, Paul Burstow predicted a wave of hospital closures as a result of cost pressures.[36] The ambulance service has not been insulated from the impact of these changes. James Pavey, Senior Operations Manager at SECAmb confirmed in an email (September 5th 2014) that the closure of hospital units had necessitated longer ambulance journeys to alternative centres for treatment and hence "longer job cycle times." [37,38]

Mr Pavey also highlighted a further issue that has received wide media coverage because of its impact upon a large number of patients in the last year:

> **"One of the most serious issues is related to handover delays at A&E departments, something that has become widespread across the country, and has a substantial impact upon the 999 system and responding to patients."** [39]

When patients are taken to A&E, ambulance staff have to wait to transfer responsibility for patient care to the hospital medical staff. This may lead to delays in ambulance crews responding to other jobs. Sometimes for example, a crew may have to wait until tests or other observations are carried out before the patient is admitted. Once transfer is complete, the ambulance must be prepared to make it ready to respond to other patients, further increasing total job turnaround time.[40]

2.3 What's the impact upon patients?

As we have shown, not all emergency calls are comprehensively monitored, so many of the effects of rising demand and policy changes may not be visible through NHS sources of information. The impact upon patients and their families is tangible and often reflected through media reports and public interest research. In the course of our investigations it became clear that ambulance trusts collect a lot more information about their performance than they release to the public. However, systems differ between trusts and the information published by NHS England is narrow. In subsequent sections we examine the evidence from ambulance staff about the effect on the standards of patient care, drawing upon the qualitative responses to a survey of ambulance staff.

What does the data from NHS England tell us?

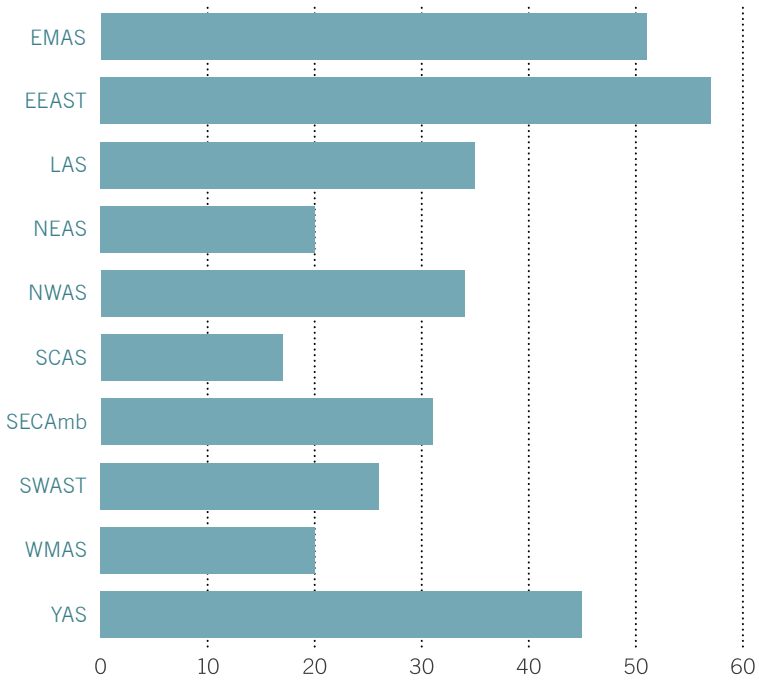
Although limited in its scope the data collected by NHS England does confirm that ambulance trusts are experiencing difficulty in coping with demand and that some patients are enduring a poor service. The figures show that more trusts are missing response targets and large differences are emerging in quality measures between areas. There has been a rise in complaints and in the number of serious incidents and failures.

Category-A response targets

In general, Ambulance Trusts are struggling to meet the main response targets. Despite a recent improvement in April 2015 – nationally the 8-minute response target was missed every month since April 2014. This is the worst performance period against this target since June 2012, when it fell close to 65% and 60% for Red 1 and Red 2 respectively. Figure 2 shows the number of times that each trust breached the target of responding to 75% of Category-A emergencies within 8 minutes.[42]

Nationally, the percentage of Category-A Red 1 (serious and urgent) incidents in May 2015 that received an emergency response within eight minutes was 76.7%, but this was the first time that this target had been in reached in since April 2014. The number of Category-A Red 2 (serious but less urgent) incidents that received an emergency response within eight minutes was 73.2%, a fall from the 77.5% performance recorded in July 2012. Figure 3 shows the Category-A response time performance between 2012 and 2015. There was a dramatic fall in the percentage of responses within the eight minute target during the winter months of 2014, with December marking the lowest point since the current call categories were introduced in 2012.[43]

Figure 2
Monthly breaches of Category-A8 targets
July 2012 – April 2015



Measures of ambulance clinical quality

In 2011 ambulance performance also began to be assessed by a number of quality measures. A performance measure known as Survival Until Discharge Following Cardiac Arrest[ii] is commonly included along with response time in discussions about performance.[44] There are large disparities in survival rates across the country[45] as Figure 4 shows. In January 2015, an average of only 9.1% of patients survived until discharge from hospital after resuscitation by EMAS. In contrast, an average of 40.0% of comparable patients resuscitated by the Yorkshire Ambulance Service survived.[46]

Complaints and Serious incidents

The growth in demand has been followed by an increase in the number of complaints and Serious Incidents (SIs) recorded by trusts.

Figures from the Health and Social Care Information Centre show that in 2013-14, there was more than a 28% percent rise in complaints against ambulance crews. This is far higher than the growth in complaints in the NHS as a whole, which rose by 5%. The Royal College of Paramedics said that the biggest single cause of complaints was delays.[47]

The number of complaints received by LAS for example, rose from 576 in 2011 to 1022 in 2014.[48] Complaints rose for NWAS from 386 in 2011, to 2078 in 2014.[49]

The number of serious Incidents recorded by SECAmb rose from twenty-two in 2011 to forty-four in 2014 and from twenty-two for LAS in 2011 to thirty-nine in 2014.[50]

ii There are several measures of Survival until discharge. The utstein comparator group is used in this report because this provides the most comparable measure of ambulance response to cardiac arrest.

Figure 3
Percentage of Category-A (Red-1&2) calls answered within 8 minutes
July 2012 – May 2015

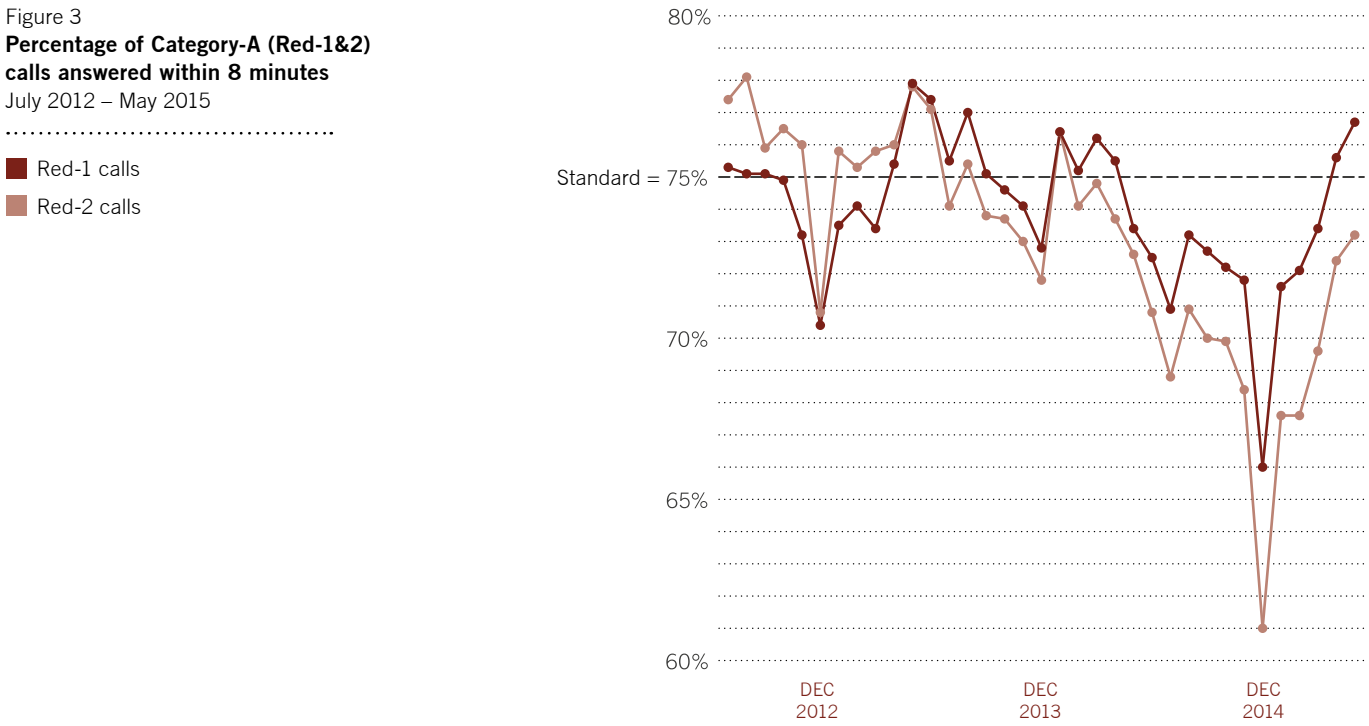
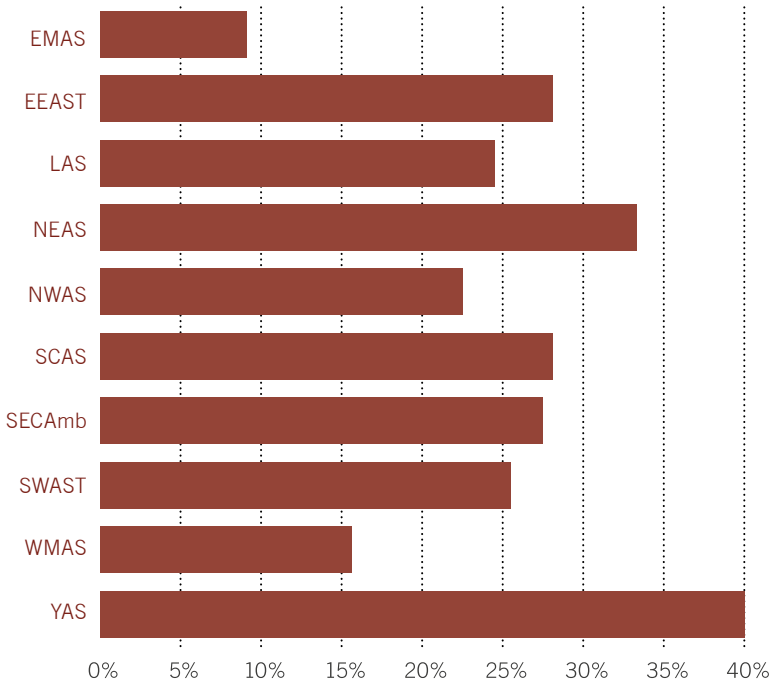


Figure 4
Percentage of patients surviving until discharge
January 2015



3. Critical staffing insufficiencies

3.1 Recruitment and demand

The drive for efficiency savings across the ambulance service has particularly affected its staffing, as this accounts for 80% of costs.[51] Consequently achieving staffing levels that can keep pace with demand has been a challenge for all trusts. Martin Berry, executive officer of the Royal College of Paramedics, told The Independent in August 2014 that: "We have seen a massive increase in demand and there has not been the financial investment to meet that increase." [52]

Training

In just over half the trusts that we sampled with Freedom of Information requests, overall expenditure on training in 2014 was still lower than in previous years.[53] Figure 5 shows the downward trend over the last three years.

Numbers of paramedics

Between 2011 and 2014 most of the ten ambulance trusts each gained a few hundred extra paramedics (see Figure 6). In three trusts there has been little or no increase in numbers. NWAS gained 1835 paramedics between 2013 and 2014 and SECAMB gained 102.[54]

These numbers fall short of recruitment targets and demand. A spokesperson from the Department of Health said in August 2014 that:

> **"...there are over 16 per cent more paramedics than there were in 2010. However, we know more needs to be done and that's why all ambulance services are actively recruiting and we are making sure we have enough paramedics trained for the future."** [55]

In September 2014, I asked James Pavey at SECAmb why these additional numbers of paramedics were insufficient. He stated that:

> **"I can't speak for other organisations but we have found that because demand has increased for many years at or around 5% it has been challenging to keep pace with recruitment demands ... ten years ago the percentage was below what was required so even though there was a 16% increase that is not enough."** [56]

An indication of the effects of understaffing can be seen in the response to a survey of ambulance workers who are members of the union Unite. 53% said that their individual workload had increased considerably compared with the same time last year. 28% said that increased workload had a negative impact on patient care.[57]

Staffing cuts and vacant posts

Exacerbating this situation, several trusts have recently announced budget cuts. NWAS is cutting £13.8 million with a decision to leave vacant posts unfilled and the possibility of future job losses.[58] EMAS has to implement £6.2 million in cuts.[59] Forced to save £53m, in April 2011 London Ambulance Service announced plans to cut staff by 890 over five years. It confirmed it intended to achieve this partly by not filling vacancies. Staff warned that this would affect the service to patients.[60]

The chairman of the College of Paramedics, Professor Andy Newton, stated on 6th April 2014, that the rise in demand has not been matched by the numbers of extra staff being taken on and that nationally there are approximately 2,500 vacancies for paramedics.[61] Similarly, in a letter dated 5th September 2014, James Pavey stated that "most trusts have an overall shortfall of operational staff" and added that he would "like to see the majority of staff as paramedics." [62]

Changing roles and skill mix

Although it is often assumed that all ambulance staff are paramedics, ambulances crews may be composed of a number of different grades of staff which may include:

Emergency Medical Technicians (EMTs)
Emergency Care Assistants (ECAs)
Emergency Care Support Workers (ECSWs)

The role of EMT is now being phased-out, but used to require a six week course covering ambulance aid and a three week course in emergency medicine. EMTs are able to deal with a greater variety of drugs, treatments and conditions than ECAs and ECSWs but receive less training than paramedics.[63] Phasing out of the EMT role is controversial amongst ambulance staff. Many think the ideal system should be a double-manned crew made up of a paramedic working with an EMT, as both staff are qualified in contrast to ECAs and ECSWs, who are classed as unqualified assistants.

ECAs and ECSWS are trained to assist EMTs or paramedics and receive a 6-9 week in-service training course including moving and handling techniques, first aid and safe driving techniques.[64] They are permitted to begin resuscitation as Basic life support but not to an advanced level and cannot transport emergency patients to hospital.[65]

Crucially, amongst the different ambulance crew roles only paramedics are state-registered professionals qualified to exercise independent clinical judgment.

Figure 5
Ambulance trusts total expenditure (£s) on training
2011 – 2014

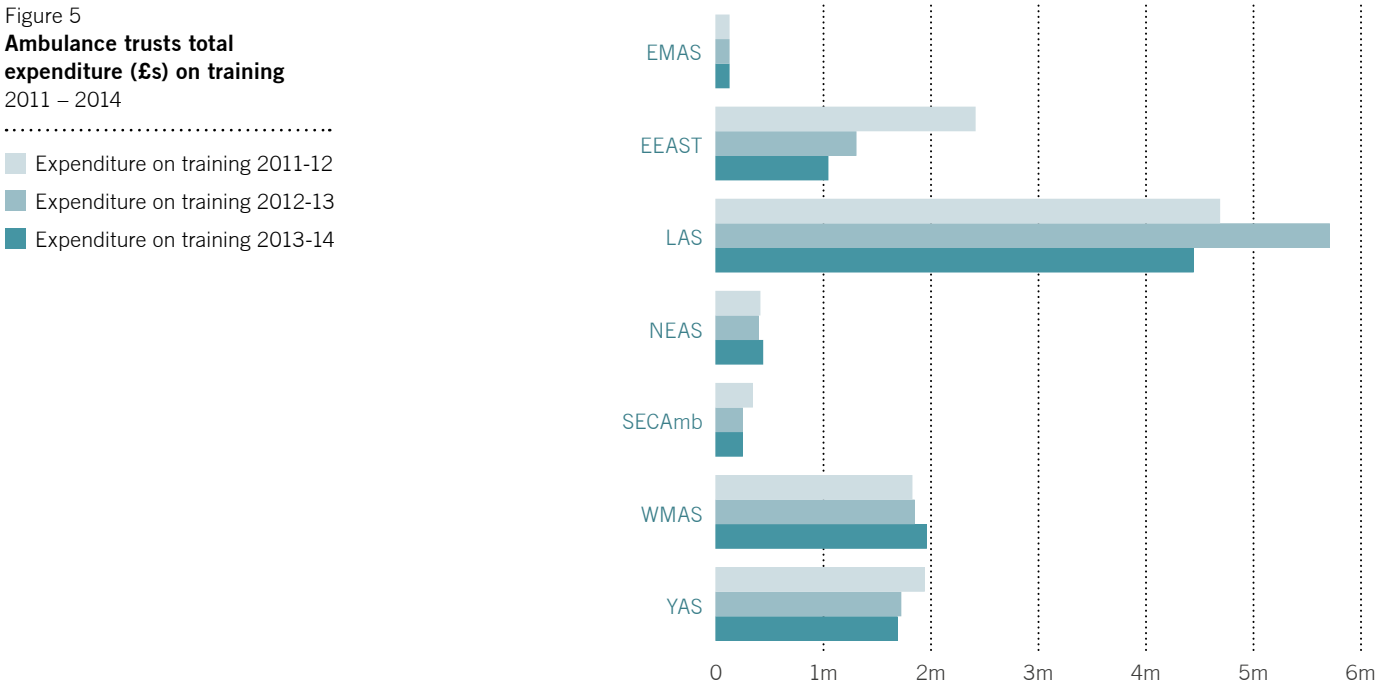
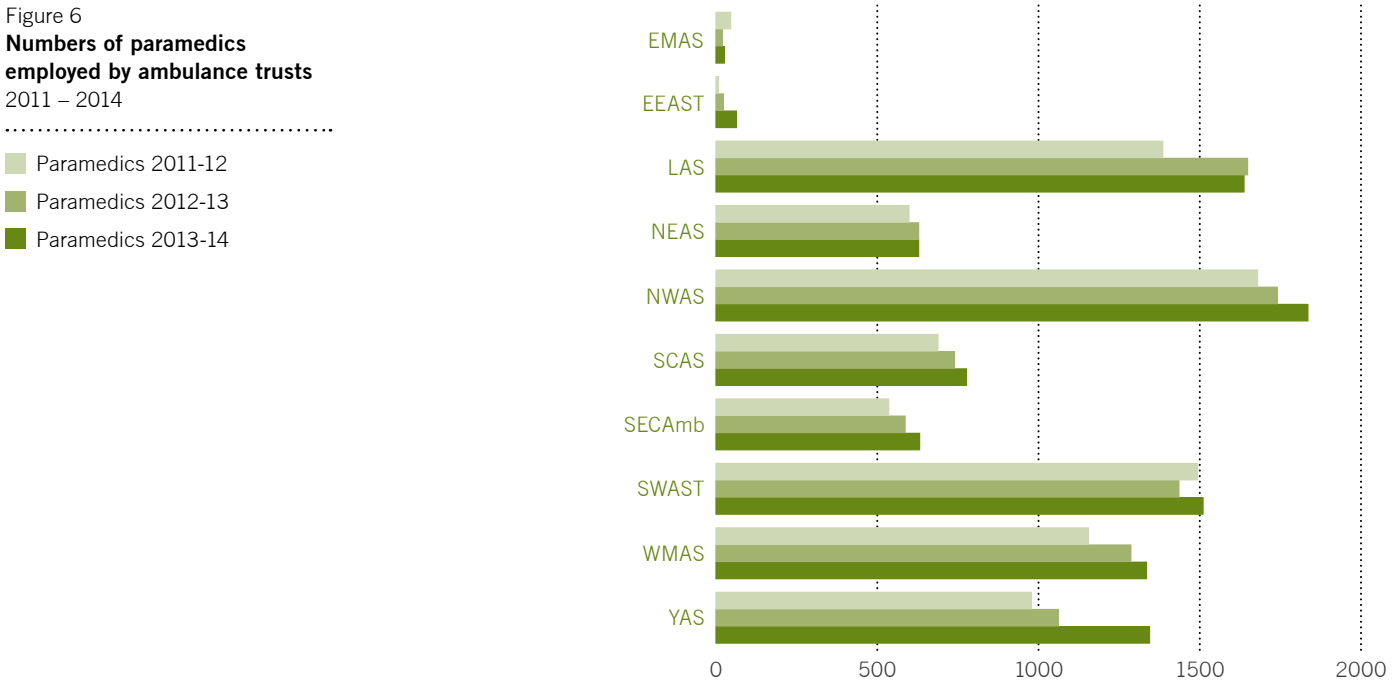


Figure 6
Numbers of paramedics employed by ambulance trusts
2011 – 2014



Paramedics may either receive training as student paramedics within a hospital or study for a diploma in Paramedic science at university. They are also increasingly trained by a three year degree and by 2016 this will be the only accepted route.[66] Paramedics have a far greater range of skills and clinical competencies including: advanced airway, trauma and incident management and advanced life support techniques.[67]

There are also a number of senior paramedic roles with a range of titles including Emergency Care Practitioner, Paramedic Practitioner (PP) and Critical Care Paramedic (CCP).[68] Senior paramedics are trained to give primary care including the treatment of minor injuries and illness and making referrals.[69] Critical Care Paramedics receive additional training to manage critical injury or illness.[70] Unite representatives working in the ambulance service informed us that the upskilling of paramedics to senior paramedics enables ambulance crews to 'see and treat' patients and reduce the number of A&E admissions. This way of allowing more patients to be left at home and referred to alternative care pathways was advocated in the recent Keogh report.[71]

iii The proportion is calculated here as the number of paramedics expressed as a percentage of the total number of paramedics, EMTs and ECAs/ECSWs for each trust.

3.2 The importance of paramedics

The importance of greater paramedic support has been confirmed by research looking at the chances of survival from out-of-hospital cardiac arrest. A study based In Nottinghamshire found that the survival chances were greater when a "paramedic crew were either called to assist technicians or dealt with the arrest themselves." [72] Despite a continuing debate concerning the relative merits of basic or advanced life support techniques,[73] a number of other studies have supported the importance of paramedics in achieving good outcomes for pre-hospital patients.[74]

In addition to the positive effects that paramedics may have on the survival of conditions such as cardiac arrest, their greater training can improve clinical decision making and reduce the risks associated with emergency treatment. These risks are particularly accentuated for the elderly or those with existing serious illness.[75]

As of March 2014, the two Trusts with the lowest and second lowest ratio of paramedics to other ambulance staff, were EMAS (12.5%) and EEAST (38.8%).[76,iii] Trusts' performance will be influenced by a range of additional factors such as the overall numbers of operational staff, the types of vehicles used by trusts and the total number of emergency calls received. However it is worth noting that the above two Trusts had the lowest (12.9%) and third lowest (17.31%) average Survival Until Discharge for the last quarter of 2013-14.[77]

What's the impact of a lower mix of paramedics?

Despite trusts' attempts to increase the number of paramedics, there is evidence of an increasing and often inappropriate reliance on less trained ambulance staff. Some crews have no paramedics on board but are composed of two technicians. Clearly crews should only be sent to calls they are trained to deal with. In the Unite survey of ambulance staff it is evident that failure to adhere to this way of working is leading to threats to patient safety and a rise in inefficiency. An ambulance Resource Dispatcher told us of the practice of "constant manning of two EMTs together, who constantly need paramedic back up." [78]

One technician described a case of a **"double EMT crew sent to an infant who had stopped breathing, with no paramedic back up."** [79]

In addition to the lack of paramedic support for ambulance technicians, many ambulance staff have told us that crews comprised of ECAs are being left to deal with emergencies without more qualified support. Another paramedic outlined an instance of "double emergency care assistant crews attending cardiac arrests and pediatric emergencies and not receiving backup from qualified staff." [80]

Concern about the use of double ECA crews was expressed during a Select Committee meeting on Urgent and Emergency Services in 2013-14:

> **"As a result of the drive for efficiency savings, the deployment of double crewed Emergency Care Assistants (ECAs) is becoming an increasing common policy in some ambulance trusts, despite advice from other trusts who have discarded this model due to the clinical risks involved."** [81]

Increasing the paramedic skill-mix to meet demand and enhance patient safety

In 2013, Mark Docherty, then Ambulance Commissioning Director at West Midlands Ambulance Service (WMAS), told a Select Committee of his goal to "ensure that every vehicle has a paramedic on board." [82] He said that in the case of WMAS this would require a 70% paramedic skill-mix. The exact percentage necessary to achieve this goal he states, would vary depending on how many single or double crewed vehicles are currently used by a trust. Fewer paramedics are needed if more double crewed ambulances are used for example.[83]

Now Ambulance Commissioner at the London Ambulance Service, Mr. Docherty states that a registered professional on every ambulance was "important if we are to manage demand and ensure we don't add to system pressures." [84] He explained that greater numbers of paramedics are required because a substantial proportion of the growth in demand has come from the need for ambulance services to give urgent primary care. Registered professionals can treat on scene without conveyance or referral to another service. Mr. Docherty also emphasized that paramedics can reduce the number of ambulances that need to be sent:

> **"If there is a paramedic on every frontline vehicle then there is a greater chance of reducing the multiple vehicle attendance ratio – you don't for example have to send a back-up vehicle just because the patient needs something that only a paramedic can do."** [85]

In addition to emphasising the operational advantages of a greater paramedic skill-mix, Mr Docherty told me that the public had a right to expect that there would be state registered professionals within any ambulance crews attending them.[86]

There is considerable variation across the country with some areas falling well below even a 50% skill-mix. Addressing the subject of ambulance skill-mix nationally and within SECAmb, James Pavey stated that:

> **"Most trusts would like to be at around more than fifty per cent paramedics, but there are variances across the country – my area (East Sussex) currently has forty-eight per cent paramedic staff."** [87]

3.3 The importance of paramedics in saving lives: my family's experience, an account by Nick Turner

The standard of ambulance care that my mother Lynn Turner received in 2013, illustrated the difference that the presence – or absence – of a qualified paramedic can make. It provides one example of why, as senior figures in the ambulance service agree, it is simply not acceptable for the public to be treated by non-professionals. What happened to my mother also illustrates the problems that can arise when the decision to request paramedic support is dependent on emergency software systems and call handlers trained in first aid[88,89] or the patient assessment skills of lesser-qualified ambulance staff.

The risk of poor clinical decisions being made by lesser-qualified ambulance staff is accentuated when crews are faced with the special requirements of patients with severe chronic diseases. To those such as my mother suffering with Motor Neurone Disease (MND) for example, the normal high-dose oxygen routinely given by many ambulance crews, may itself present a serious risk of suppressing a patients' breathing reflex. According to guidance issued by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), patients with conditions such as MND, Chronic Obstructive Pulmonary Disease (COPD)[iv] chest wall disorders, morbid obesity or cystic fibrosis, should be given controlled or low-dose supplemental oxygen.[90]

When my mother collapsed on 2nd October 2013, my father called 999 and two SECAmb ambulances were sent. The first to arrive was crewed by two EMTs. This crew took the decision to stand down the second ambulance (staffed only by an EMT and an ECSW). Both the failure of SECAmb's Emergency Operations Centre (EOC) to have initially sent a paramedic to the scene and the failure of the first crew to immediately request one, were to have very serious consequences.

The Trust accepts that that my mother was still able to breathe by herself when she entered the ambulance and was communicating with staff by means of writing on a white-board. My father observed that following the administration of high-dose oxygen, my mother went into respiratory arrest and had to be resuscitated. Only then was a paramedic sent to the scene. My mother was left in a considerably weakened state by these events. She died two days later after a year-long struggle against her disease.

JRCALC guidelines stipulate that administration of oxygen should be based upon proper clinical observations. The Trust apologised for failures by the first crew attending my mother, to make these observations or listen to important information that my father tried to convey to them about my mother's condition.

Most importantly, my father told them that he had just measured my mother's blood saturation at 97%, which is within the normal range even for healthy individuals. This indicated that she did not require high flow oxygen. Paul Sutton admitted in his letter of 18th December 2013 that whilst the crew had not attempted to measure her blood saturation before taking her into the ambulance:

> **"...they recall Mr Turner said the saturation level was normal when he put the pulse oximeter on Mrs Turner. Our staff should have done more to properly establish what Mrs Turner's normal level of oxygen saturation was and we are sorry they did not do this when they had the opportunity to do so."**

The crew noted that my mother had difficulty lifting her head and had swallowing difficulties. My father attempted to tell the crew that her symptoms, rather than being something new, were a result of her MND. In his letter the Chief Executive wrote:

> **"Mr Turner had attempted to volunteer pertinent information to the crew ... however, the crew failed to take full and proper account of what was trying to be conveyed to them ... it is necessary for ambulance staff to obtain a full set of clinical observations on patients ... to enable them to properly assess what treatment may or may not be appropriate. On this occasion it did not happen, despite the opportunity to take a proper set of clinical observations before taking Mrs Turner into the ambulance."** [91]

The ambulance crew attempted to suggest that their failure to take account of what my father was telling them was because he was distressed about my mother's condition. The Trust rejected this attempt to blame family members for the crew's poor listening and observation skills and have issued an apology.

The Trust have refused to accept full responsibility for the clinical failures and inadequate training of its crew however. When SECAmb carried out its own internal investigation, the ambulance crew denied administering oxygen prior to my mother suffering respiratory arrest and SECAmb has chosen to simply accept this. This is despite the fact that the Trust's Senior Operations Manager, James Pavey has confirmed that the administration of oxygen by lesser-trained crews would at that time have been a normal practice that has since had to be revised. In his letter dated 18th December 2013 SECAmb's Chief Executive Paul Sutton wrote:

> **"During his interview with our staff, Mr Pavey was surprised to learn that in this case the crew had not given Mrs Turner any oxygen before she suffered the respiratory arrest, as often in similar circumstances it may well have been given routinely."** [92]

iv Conditions such as COPD are extremely common. In the Trust's Disclosure Log, a Freedom of Information request in November 2013, showed that in that year alone, SECAmb attended 2328 patients with COPD.

3.4 Ambulance trusts claim that all staff are equally able to deal with any clinical situation

In the course of this research a distinct picture about call handling started to emerge. It became clear the decision about which crew is sent to answer a call is often governed by the response time rather than the level of expertise that a particular emergency may require.

In a reply to my FOI request in March 2014, NEAS told me that "dispatch of clinical staff is determined by the priority of call and not the clinical condition." [93] Whilst it may often be important to stabilise some patients before more qualified staff arrive, as my mother's case demonstrated, the appropriately qualified crew may never arrive because they are not dispatched to begin with or requested by an attending crew.

In the continued absence of paramedics on every ambulance, many trusts maintain that ECAs and EMTs are equally able to respond to any clinical emergency. In March 2014, I sent out Freedom of Information (FOI) requests to ten ambulance trusts asking them if they had regulations which stipulate the minimum level of training that crews must possess in order to respond to certain types of call. Using Motor Neurone Disease or COPD as an example, I asked if there are any circumstances or medical conditions to which they would deem an EMT or ECA to be unqualified to respond and to which they would send a paramedic instead. A typical example of the responses that I received was that of NWAS:

> **"I can inform you that we do not have separate minimum levels of training for different categories of emergency call. The principle we work to is that all crews have the necessary skills, training and experience to respond to whatever emergency that they are called to."** [94]

Despite such assurances, several ambulance staff have told us that the crews being sent out without paramedic backup are often insufficiently qualified to deal with the clinical situations that they encounter.[95] Without adequate resourcing, this is a problem that is set to become worse as demand on the ambulance service grows.

3.5 SECAmb changes its policy on oxygen administration

In the year following my mother's death, SECAmb has instructed its lesser-trained ambulance staff to administer oxygen based on "relevant observations and physiological markers such as blood oxygen saturation."[96] The Trust says that it took this initiative after it "challenged itself to reduce the number of patients admitted to hospital following over-oxygenation." Whilst additional training may be put in place after particular problems such as over-oxygenation have come to light however, for affected patients and their families, such piecemeal initiatives will come too late. Many will feel that it would be better to prevent such occurrences in the first instance, by having more state-registered clinical professionals in ambulances.

As part of their training, paramedics already learn to administer oxygen based upon proper clinical observations. In June 2014, I asked Mr Pavey about whether a paramedic initially attending my mother would have taken a different decision specifically about the administration of high-flow oxygen. This question would not have been relevant if it had not been administered to begin with. In response Mr Pavey began by emphasising that all grades of ambulance staff were now trained to administer oxygen based on appropriate observations. Whilst expressing some difficulty in stating "Whether or not a paramedic attending in the first instance would have made a difference to treatment," he conceded that, "it could be reasonable to expect that their clinical assessment would have been more in depth than that of a technician."[97] My family believe it to be unacceptable that whilst professional standards are expected in many areas of everyday life, people still cannot depend on being attended by a professional when their lives are at stake.

> **"Although ambulance staff work to national guidance, it is reasonable to assume that individuals with higher levels of clinical education and training will make better clinical decisions ... Paramedic Practitioners (PPs) have greater clinical competencies, compared to Technicians who receive a six to eight week training course. Therefore PPs are able to conduct a more in depth clinical assessment of a patient's condition and provide treatments accordingly..."** [98]

4. Ambulance Trusts' responses to the problem of under-capacity

4.1 Further steps in managing demand: 'demand reduction'

Pressure has come from government for trusts to find efficiency savings under the QIPP initiative.

> **"The pressure to manage and use Trust finances ever-more prudently will grow, and there is no reason to suggest that the trend of annual increases in the number of 999 calls the Trust receives each year will not continue. Finding better and more appropriate ways to respond to patient need, without necessarily sending an ambulance resource, will be essential in ensuring the Trust continues to provide high-quality care to all our patients."** [99]

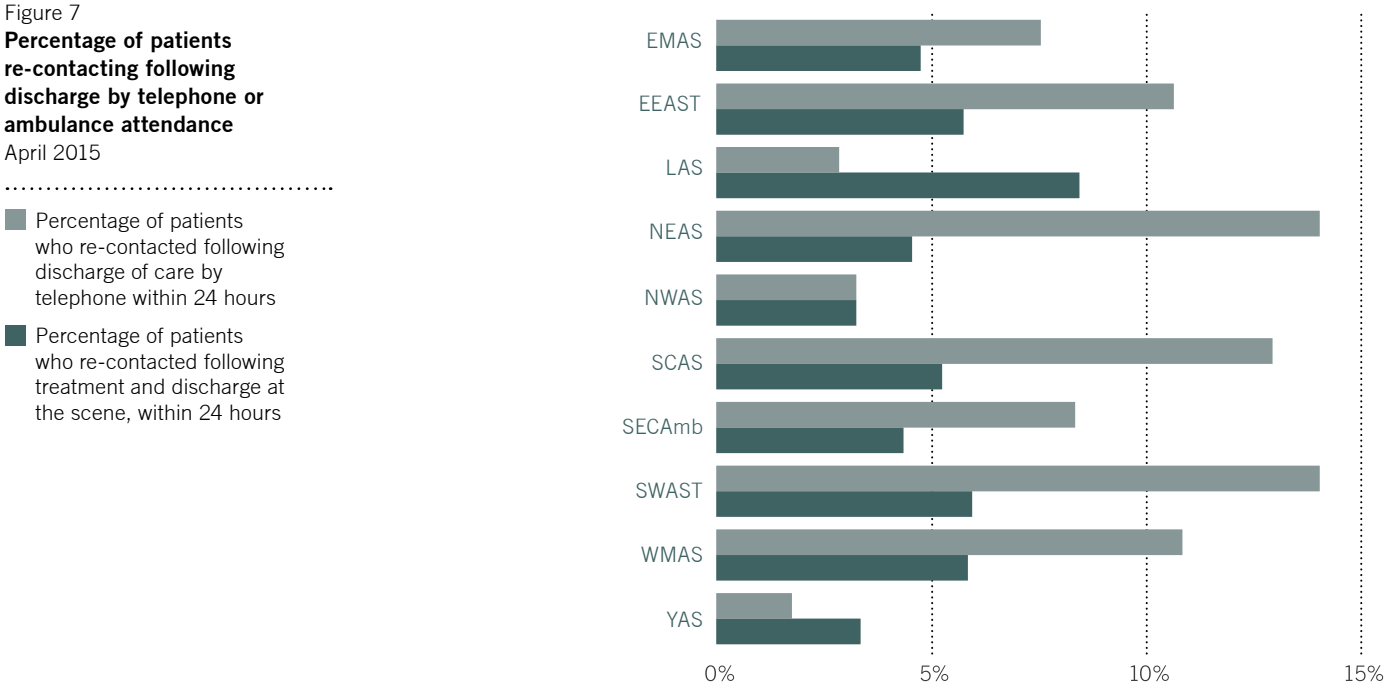
There has been a growing tendency for trusts to attempt to manage demand. In 2009, the NHS document Tackling Demand Together emphasised the need to change public attitudes to calling 999 as well as to tackle the problem of frequent callers.[100] Peter Bradley, London Ambulance Service Chief Executive, has stated:

> **"Our whole plan is based on seeing fewer ambulances sent to calls and fewer patients transported to A&E. You can't stop people ringing so we have to take responsibility to do something different with their calls ... I think we can save tens of millions for the rest of the NHS."** [101]

The document recognised however, that in London "just under 75% per cent of the increase in ambulance incidents" were related to four types of incidents: "breathing problems, unconsciousness/passing out, chest pain and traumatic falls/back injury" [102] – that is to say, potentially serious clinical conditions.

In a recent Strategic Forward plan of the West Midlands Ambulance Service, factors such as public attitudes to calling 999 or frequent callers were not mentioned, even as potential drivers of demand. Instead, the document cites "health and demographic analyses which show that population growth will be greatest in the 60+ age group who are those most likely to use the ambulance services." [103] A large proportion of increased demand moreover, results from the success of health awareness campaigns such as the stroke awareness campaign Acting FAST that encouraged people to take their symptom seriously and call 999.[104] According to Caroline Watkins Professor of Stroke and Older People's Care at the University of Central Lancashire, the most concerning problem is not peoples' over-willingness to call 999, but delayed dialing. She writes of patients' continued reluctance to "bother a doctor or other medical staff when ill." [105]

Figure 7
Percentage of patients re-contacting following discharge by telephone or ambulance attendance
April 2015



4.2 Triaging

The idea that trusts should discourage people from calling 999 and 'tackle' demand continues to influence policy. There are now financial incentives offered to Trusts by the Department of Health to 'triage-down' emergency calls and reduce the proportion of those calling 999 who are taken to A&E.[106]

999 calls to ambulance services, are assessed or 'triaged' in Emergency Operations Centres (EOCs) by call handlers using resource allocation software (NHS Pathways or the Medical Priority Dispatch System).[107] Using a triaging practice termed 'hear and treat', alternative pathways to an ambulance response or A&E admission are sought. Where an ambulance response is necessary, if possible, "see and treat" is used to triage down cases rather than admit them to hospital.[108] This has proved controversial. In 2013, trust executives told a select committee on Urgent and Emergency Services that greater numbers of paramedics are necessary in order to cope with demand however.[109]

4.3 Concerns about the reliability and safety of telephone triaging

Without the aid of physical examination, telephone triaging is dependent on patients' description of their clinical problems. This limitation may be reflected in re-contact statistics. In April 2015 for example, 5.2% of patients felt the need to re-contact South Central Ambulance Service after being treated and discharged by an ambulance crew at the scene, where as 12.9% of people felt it necessary to call for an ambulance again 24 hours after discharge by telephone (see Figure 7). This was a pattern that was repeated nationally, with seven out of ten Trusts having higher re-contact rates after discharge by telephone than discharge by an ambulance crew.[110]

The lack of nationally recorded information about a large proportion of emergency calls, raises concerns about how assured the public can be about the safety of the triaging process.

In 2010 it was estimated that a software flaw responsible for wrongly categorising calls, may have contributed to hundreds of deaths over a period of years.[111] Serious problems can also result from human error. SECAmb has stated that there were two Serious Recordable Incidents resulting from triage and seventy-eight complaints and PALS enquiries since the NHS Pathways software system was implemented.

Among the causes that the Trust identified were "All grades of staff failing to take account of callers'/patients' concerns," and "Staff failing to listen actively to what they were being advised."[112] A senior manager at SECAmb that I spoke to, conceded that there is a limit to how much demand can be reduced using triaging. He stated that while any triaging will carry some level of risk, triaging-down more than ten per cent of calls is generally considered to be unsafe. I put it to him that even with respect to this ten per cent it was difficult to establish how safe the triaging was, because no information about forty-five per cent of (Green category) emergency calls is contained within NHS England's' national quality statistics. In response, I was offered the reassurance that information about Green calls is held by Trusts themselves and that in cases where things do go wrong, that this information would be available in the form of coroner's reports. The Manager conceded however, that it would be better to have information about these calls held on NHS England statistics and that this might be something which could be addressed in future.

4.4 Asking ambulance staff to work harder

Our earlier analysis of NHS England's data on ambulance performance showed that despite initiatives designed to 'reduce' demand, trusts are continuing to struggle to cope. The strategic assessment of one Trust was:

> **"Demand management has yet to be successful and we have seen a steady increase in demand in recent years."** [113]

With inadequate staffing levels and rising workload, in practice, ambulance crews are often being asked to shoulder the burden of this increased workload. In 2012, a report by SECAmb stated that:

> **"For operational crews, the NHS Pathways system was sold as a panacea that would reduce the numbers of calls that crews would be attending ... [however] any improvements in Hear & Treat rates have not translated into less busy working lives for staff, work-loads have increased."** [114]

The reality of how demand is managed by under-resourced Trusts is indicated by Unite's Health Pay and Terms Survey 2013 (Fig 8). Members were asked how their workplaces were responding to the financial challenges facing the NHS. Whilst 21.1% emphasised restructuring of services, 22.4 % emphasised changes to their working terms and conditions as the main way in which their Trusts were responding to under-resourcing.

In the same survey, 53.3% of ambulance workers said that compared with the same time last year, their individual workload had increased considerably.[115]

Rather than increasing productivity, this excessive workload is having negative effects on performance. 27.5% of ambulance workers said that increased workload had a negative impact on patient care. In an additional survey of ambulance workers opinions that Unite conducted in association with the NHS Support Federation, one paramedic told us that:

> **"Crews are literally on the go every shift, often going out on an emergency calls without any opportunity to check the drugs or vehicle. Crews are exhausted as they finish on average 15 minutes to 2 hours late at the end of their shift time. This increases sickness levels and thus puts extra strain on an already over stretched service."** [116]

In February 2014 Yorkshire Ambulance Service proposed the introduction of new shift patterns that would force paramedics to work twelve hour shifts and go without a meal break.[117] This was opposed by staff. Nearly 400 Unite Yorkshire ambulance members held a series of strikes in this dispute since April 2013, Unite commented on its website,

> **"The crux of the dispute, which is now 18 months old, is the introduction of elongated shift patterns. The union has said that it is only a matter of time before someone is seriously injured or killed as a result of staff exhaustion."** [118]

A survey of 1300 ambulance staff carried out by Income Data Services reported that 84% said they frequently or always worked for longer than their contractual hours – 20% higher than for all NHS staff. Similarly 85% reported frequent staff shortages over the last 12 months – 13% higher than for all NHS staff.[119] 56% said their workplace had undertaken a restructuring. 77% of respondents felt that morale had got worse, again 13% higher than the figure for all NHS staff.

4.5 Using less experienced staff to make sure targets are met: 'clock stopping'

Ambulance crew members have told us about trusts' practice of formally meeting response-time targets but subsequently failing to ensure adequate paramedic care. An initial response is made by an ECA staffed crew or community first responders (volunteers trained in first aid and equipped with defibrillators). A paramedic told us that the failure to then back-up lesser trained staff and first responders is costing lives:

> **"Fast response vehicles are sent to Category-A 8-minute emergencies. Often they are left waiting as there are no ambulances to back these vehicles up. There appears to be 'they have stopped the clock' mentality among senior management but patients have deteriorated and actually died while single responders end up having to initiate Basic Life Support ... Patients' families are forced to watch as their loved ones deteriorate in front of them."** [120]

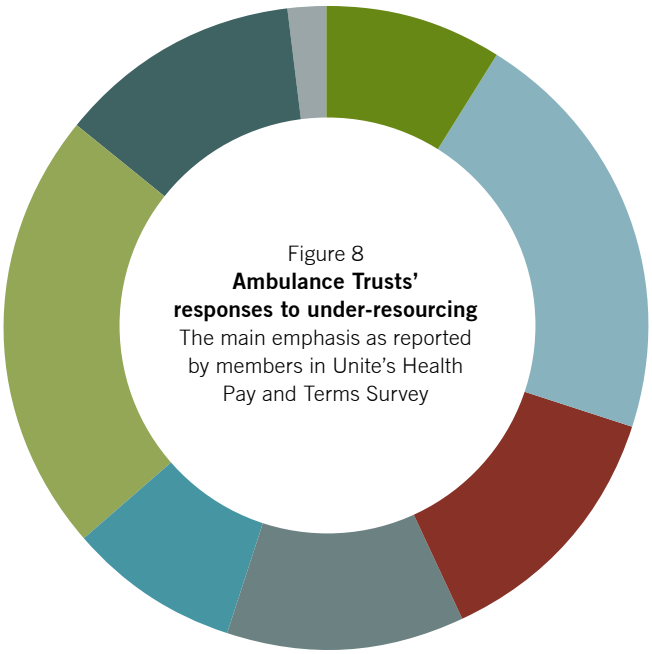


Figure 8
Ambulance Trusts' responses to under-resourcing
The main emphasis as reported by members in Unite's Health Pay and Terms Survey

5. The use of non-NHS ambulances to cope with increased demand

Most people will be aware of the use of taxis and private ambulances to perform routine non-emergency patient transport.

In 2014 Sir Mike Richard's Care Quality Commission report revealed that fifty percent of these journeys are now made by private ambulance.[121] However many might be surprised to learn that non-NHS ambulance crews are increasingly used to respond to the most serious emergency calls.

Non-NHS ambulance providers may include 'voluntary' (charitable) ambulances and fully commercial private companies.[v]

5.1 Non-NHS ambulance emergency attendance figures

In response to Freedom of Information requests in March 2014, trusts reported a total of 250,526 emergency responses made by non-NHS ambulances over the period June 2012 to March 2014. A total of 113,425 of these were Category-A (life-threatening) emergencies.[122]

This was followed up with a further batch of FOI requests for the period between January 2014 and April 2015. The new data revealed that non-NHS ambulances responded to 139,086 life-threatening emergencies and 313,661 emergencies. Private providers took up 89% and voluntary crews 11% of non-NHS attendances in our study.

Between January 2014 and April 2015, non-NHS ambulances responded to more than 139,000 life-threatening emergencies

Over the last 16 months there has been wide variation between the ambulance trusts in the use of non-NHS providers: South Central used 17%, North East 9%, South East 9%, East of England 5% and London 5%. Where as North West, South West, West Midlands and Yorkshire Ambulance Services all have non NHS useage of less than 1%.[123] Overall there has been an increase in the use of non NHS providers in comparison with our first FOI in 2014.

All ten Trusts admitted to using private (commercial) ambulances to respond to life-threatening emergencies.[124]

For nearly all trusts, the largest use of non-NHS responses was for Green calls rather than Red, although Green 1 and 2 are classed as emergencies. South Central use non-NHS ambulances for 17% of their Green 1&2 calls, North East 13%, South East 9%, East of England 8%.

Three trusts stood out as larger users of private providers to attend emergencies: South Central (16%), South East (8%) and London (5%). However three trusts did not provide a breakdown between private and voluntary providers, including North East Ambulance services, who use non-NHS ambulances for over 9% of all emergencies.

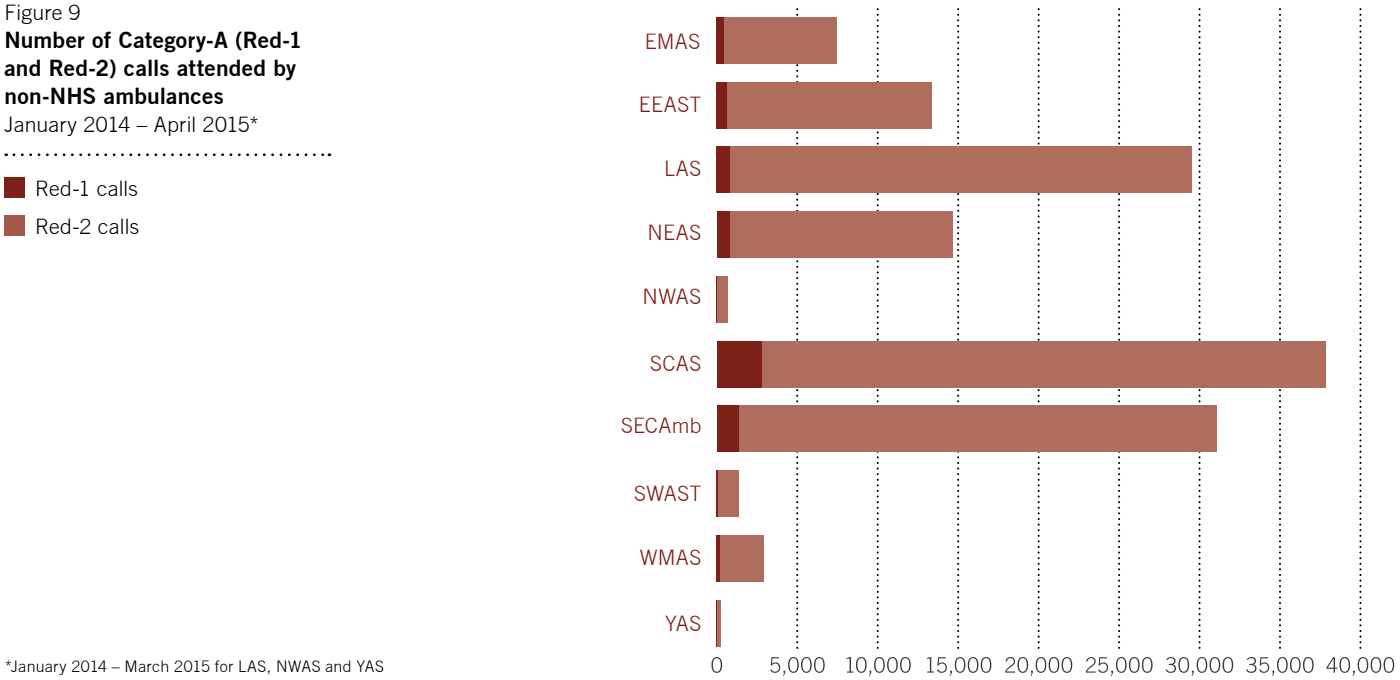
Of those trusts that could breakdown their use of non NHS providers (five trusts), total journeys by private crews were 204,143 (89%) versus 26,161 by voluntary providers (11%).

Although use of private ambulances has risen not all trusts view this as desirable. In a response to my freedom of information request in March last year, SECAmb stated that:

> **"We are continuing to look at ways in which we can reduce our reliance on the use of private ambulance services and always prioritise using our own staff whenever possible. However, along with all ambulance services nationally, SECAmb does use private ambulance providers when faced with high levels of demand."**[125]

v Separate figures for EMAS' private and voluntary ambulance use were unavailable at the time of writing this report. With significance for the proper monitoring of providers, SWAST were unable to break-down the overall figure for non-NHS ambulance use by private and voluntary ambulance provider.

Figure 9
Number of Category-A (Red-1 and Red-2) calls attended by non-NHS ambulances
January 2014 – April 2015*



*January 2014 – March 2015 for LAS, NWAS and YAS

Further investigation

NWAS states that "voluntary aided sector (VAS) resources are sometimes used to assist with transfers and non-emergency journeys, but we do not use them for Red 1 & 2 or Green 1 & 2 response." [126] In reply to my FOI request in March last year, the Trust said that:

> **"We have never discussed or seriously considered using private ambulance services to respond to 999 calls as we have never felt the need to do so. We do sub-contract some non-emergency work when we have a capacity problem, but we try to avoid doing so. It costs more, is not in our control and raises issues of compliance and governance. If we were to use a private service for an emergency we would have to ensure that the private service was registered with CQC and that all of their clinical and safety practices were in line with ours. There has simply never been a call to do this."** [127]

Despite giving these strong arguments against using private ambulances, our most recent FOIs reveal that (for reasons that are presently unclear) the trust has now begun to make some limited use of private providers.

On 21st June 2013, SWAST announced a service contract worth nearly £50m[128] for the "Provision of Private Ambulance support to Accident and Emergency Services including "Blue Light" Urgent Care and Out Of Hours." Despite this, the Trust stated in March 2014 that "we do not use third-party Private Ambulances to respond on blue lights to accident and emergency incidents, however we can use them in support of the A&E service if we have an urgent requirement to transport a patient on non-blue lights." [129]

The figures for third-party (non-NHS) ambulance use that SWAST disclosed to me however, were categorised as Red 1-Green 2 calls.[130] The Trust would appear therefore, to be using third party ambulances to respond to calls at least initially categorised as emergencies.

In response to a Freedom of Information request in February 2014 concerning the above service contract, SWAST had provided a very extensive list of third party ambulance providers that it employs on an ad-hoc basis.[131] The Trust states that in using a 'framework agreement,' it has no contract with any individual supplier. Many will find this a cause for some concern. Parties to a contract are bound by an agreement to honour certain obligations such as standards of service delivery. In place of this, it remains unclear what protection there is for patient care quality or public money in these transactions.

5.2 Concerns about the training levels of non-NHS crews

Whilst there is an insufficient number of paramedics staffing NHS ambulances, there appear to be even fewer present on non-NHS ambulances.

SECAmb, one of the largest users of non-NHS ambulances, state that "only 2% of the non-NHS ambulance crews have a qualified paramedic on board."[132]

A Director at SECAmb told me that

> **"We would never have used the private sector if there hadn't been such high levels of demand. I would rather use my own people. The private sector is many years behind and the quality far below that of the NHS....The private sector crews are composed of more support grade personnel, which they're good at supplying, but you can only get a paramedic from the NHS."**

NHS ambulance staff have similarly expressed concerns about the training of private ambulance crews. One paramedic told us that:

> **"A lot of the time the private ambulance staff are not highly trained ... To say there are numerous 'near misses' with these crews is an understatement ... this is now really putting patients' lives at risk ... These crews appear to be mainly rejects from NHS ambulance services. They do not appear to be vetted properly. The 'technicians' are often individuals who have done a 'first aid at work course'."** [133]

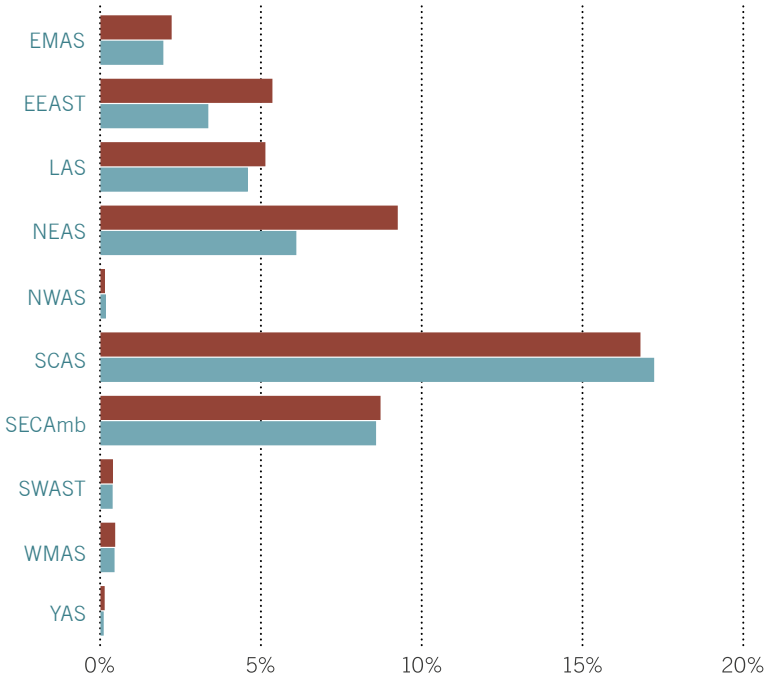
5.3 Training levels of voluntary ambulance staff

Although increasingly employed by trusts, St John's are a charity with independent training standards and do not train paramedics. One highly publicised case concerned the standard of care given by ambulance charities involved the investigation into the death of Ex-teacher William Gouldburn in April 2013. Hartlepool coroner Malcolm Donnelly said that this was "a sad consequence of a lack of resources." Two hours and seven 999 calls after Mr. Gouldburn had collapsed, a St John's ambulance crew arrived, sent by North East Ambulance Service. Mr. Gouldburn's stepson-in-law, said: "It was only when the paramedics arrived – not the St Johns – that it was clear that there was someone in control who was actually professional." [134] By then however, it was too late to save Mr. Gouldburn.

A response to my Freedom of Information request in March 2014, revealed that out of a total 126,625 Category-A (life-threatening) calls received by NEAS from June 2012-February 2014, non-NHS crews attended on 11,485 occasions. 5,482 of these attendances were made by a St John's ambulance.[135]

Figure 10
Percentage of all trusts' emergency calls attended by non-NHS ambulances
January 2014 – April 2015*

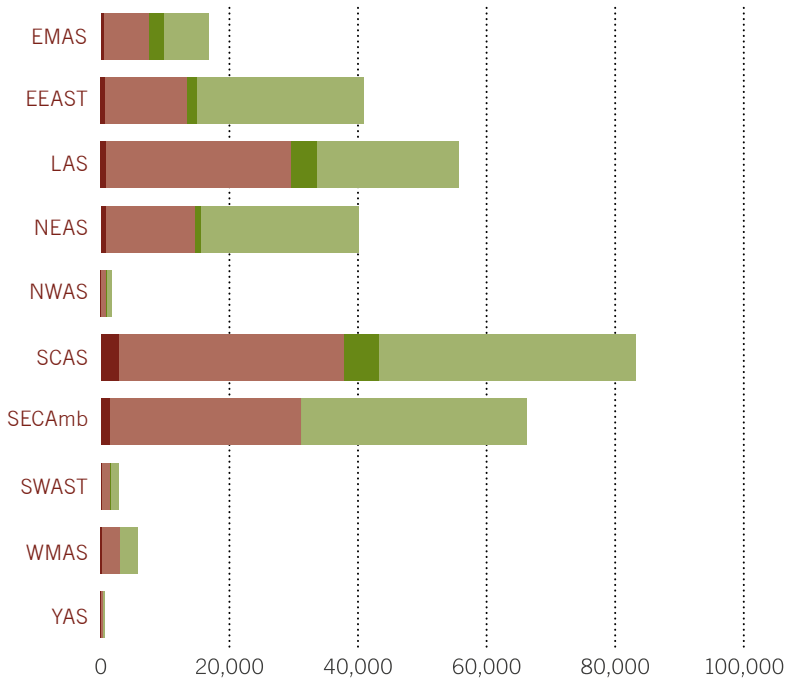
- Percentage of emergency calls attended by non-NHS ambulances
- Percentage of Category-A emergencies attended by non-NHS ambulances



*January 2014 – March 2015 for LAS and NWAS

Figure 11
Total number of emergency responses by non-NHS ambulances
January 2014 – April 2015*

- Total non-NHS Red-1
- Total non-NHS Red-2
- Total non-NHS Green-1
- Total non-NHS Green-2



*January 2014 – March 2015 for LAS, NWAS and YAS

5.4 Monitoring concerns

The Care Quality Commission has emphasised the importance to the proper regulation of ambulances, of "developing our information to monitor providers." [136] However, trusts have already acknowledged that they have found it difficult to properly monitor their own ambulances. In 2011, SECAmb recognised for example, that "ambulance trusts have no systematic way of monitoring the standards of care provided to trauma patients and clinical governance arrangements between pre-hospital and hospital care are weak." [137]

The reality is that very little information appears to exist concerning a substantial proportion of all emergency calls. NHS England does not monitor Green calls or even collect information about the number of Green calls that trusts receive. As may be seen from Figure 11, Green 2 comprises the largest category of calls attended by non-NHS providers.[138]

After 2012, most ambulance trusts became able to record information about whether calls were responded to by NHS or non-NHS ambulances and whether any Serious Incidents occurred in their care. There is considerable variation in how much information individual trusts record about their use of non-NHS ambulances to attend emergencies however. In 2014 SWAST did not record information distinguishing between attendance by private and voluntary providers for example.[139] EMAS and LAS do not record information about which particular voluntary ambulance provider is used (eg. St Johns or Red Cross).[140] The former state that "systems we have in place for this type of analytical work do not capture this information." [141] Neither LAS nor SECAMB record specific information about any Serious Incidents occurring in the care of private crews.[142] SECAmb states that is because its DATIX software, is unable to record this type of data.[143] Despite this, in its reply to my FOI in March 2014, the Trust maintained that the use of private ambulances is properly monitored:

> **"We have robust governance arrangements in place for the procurement of private ambulance services. While working on our behalf any private provider will be subject to a continuous monitoring and assessment process, to ensure they are providing a high level of service. We do not record SIRI's relating to private providers separately."** [144]

It would seem that some SECAmb executives have concerns about monitoring of private ambulances however. During a SECAmb governors meeting Monday 30 July 2012, Maggie Fenton (public governor, Kent) expressed the concern that "if private ambulance vehicles are not tracked, continuous assessment and monitoring of them must be difficult." [145]

The variable level of monitoring of private ambulance providers may come as little surprise if there is also insufficient regulation. Many ambulance staff have expressed very little confidence in the ability of even the Care Quality Commission to regulate ambulance provision. In response to Unite's survey of members, one trust manager told us for example that "the CQC does not use appropriate inspectors ... especially ambulance aware or qualified." The same manager added that The CQC "just look at policies and paper." [144] A paramedic responding to the same survey wrote that regulation was "not effective at all ... [The Trust] know about monitoring etc., and pull all the stops out to cover up their inadequacies." [147]

5.5 Trusts' concerns about the financial risks of using private ambulances

The overall monetary cost of non-NHS emergency ambulance use is indicated by an investigation in April 2014 which revealed that in three years, spending more than doubled from £24m to £56m.[148] The governors of several ambulance trusts have questioned whether private companies are the most cost-effective means of addressing a shortage of trained NHS staff. During a meeting of SECAmb Governors in 2012 for example, Nigel Sweet, Staff-Elected Operational Governor stated that "private ambulance staff are able to work less hard" because they are not tracked.[149]

He asked whether the Trust could be "confident that using private ambulances is a cheaper alternative." During a board meeting of EEAST in January 2014, Stephen Day, the Director of Finance & Commercial Services said that the Trust's "overspend on non-pay" was "largely driven by the spend on Private Ambulance Services." [150] In the same month, during a board meeting of EMAS, Jon Sargeant responded to a question about private ambulance use by the Trust, stating that EMAS 'was planning to use its own staff which would be less costly." [151]

In March 2014, The Nottingham Post revealed that because of EMAS staff shortages, non-NHS ambulance providers were paid £7 million in the previous year to respond to emergency calls. The same article revealed that "the service's own ambulances were being left unused for up to twelve hours, hundreds of times a month, because of a shortage of paramedics." [152] Ambulance trusts that use costly private ambulance providers in order to make up for under- capacity, do not only use funds that could be invested in building-up their own service. Encouraging the private sector also places Trusts' own market position and future sources of revenue at risk. Several Trusts have expressed concerns about growing competition from the private sector. In SCAS' Strategic Plan 2013-14, it is stated for example that:

> **"Currently it is unclear to what extent the NHS reforms will open mandatory services to broader or full competition. It is possible that we could see private providers in the future competing directly with existing NHS providers for the emergency services."** [153]

Summary

This report finds an under-resourced ambulance service struggling to meet the pressure of the growing number of emergency calls and additional sources of demand. Forced to implement budget cuts, ambulance trusts' response has been partly to attempt to reduce the number of emergency responses – or in the preferred terminology – to 'reduce demand'. If possible, emergency calls are now 'triaged down' and concluded over the telephone. However, there are concerns about the safety of telephone triaging particularly as no response time or clinical outcomes data is collected by the government for a very large proportion of emergency calls. As such, little national data exists about the quality of the triaging in many cases.

Despite demand reduction initiatives, trusts recognise that demand has continued to rise. Analysis of two years of monthly ambulance service statistics published by NHS England, shows that there is a marked decline in performance against national response-time targets and considerable variability in clinical quality. There has also been a rise in the number of recorded complaints and Serious Incidents. With insufficient resources, trusts have pursued a number of alternative responses to the growth in demand. Crews are being are being placed under pressure to work much harder. Senior figures within the ambulance service have stated that there needs to be a greater paramedic skill-mix in the staffing of ambulances. Despite a process of ostensible professionalisation of the service however, there is evidence that relatively unskilled crews are increasingly being left to deal with some of the most serious emergencies.

As these measures have failed to compensate for lack of long-term investment in adequate numbers of properly trained staff, ambulance trusts have resorted to using private providers. The trusts with the highest and lowest amount of private ambulance use agree that reliance on private ambulances is less-desirable than the use of NHS ambulances. Although the skill-mix of non-NHS crews is lower than on NHS ambulances, many members of the public may not be aware that these are used to respond to even the most serious emergency calls.

Despite a recent CCQ report emphasizing the need for better information on ambulance providers, there is no NHS England data specifically concerning private ambulances use, even for the most serious, Category-A emergencies. There is also a considerable disparity in the information that trusts collect about private providers locally. Trust Governors have also voiced concerns both about the monitoring and cost-effectiveness of private ambulance use.

The use of private ambulances to respond to emergencies appears set to increase and trusts have discussed private ambulance contracts as a potential threat to their own market share and future revenue.

References

1. Katherine T. Barkley (1990) The Ambulance, Exposition Press

2. http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Ambulanceservices.aspx

3. Department of Health, Report by the Auditor General, HC 1086, Session 2010–2012, 10 June 2011, http://www.nao.org.uk/wp-content/uploads/2011/06/n10121086.pdf

4. What Happens When You Call 999, East of England Ambulance Service Trust, accessed from http://www.eastamb.nhs.uk/Downloads/Behind%20the%20headlines/What%20happens%20when%20you%20call%20999%20for%20ambulance%20service.pdf

5. NEAS Ambulance Response Categories- Explained, accessed from http://www.neas.nhs.uk/our-services/accident-emergency/ambulance-response-categories-explained.aspx

6. Response to my requests under the Freedom of Information Act (2000), April 2015

7. NHS England Ambulance Quality Indicators accessed from http://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

8. Responses to my requests under the Freedom of Information Act (2000), April 2015

9. NHS England Ambulance Quality Indicators accessed from http://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/)

10. Department of Health, 10 June 2011, Transforming NHS Ambulance Services, Pub by National Audit Office, p.8, accessed 23.06.214 from http://www.nao.org.uk/wp-content/uploads/2011/06/n10121086.pdf

11. Department of Health, 10 June 2011, Transforming NHS Ambulance Services, Executive Summary, Pub by National Audit Office, p,6 accessed 3.06.2014 from http:// www.nao.org.uk/wp-content/uploads/2011/06/n10121086es.pdf

12. Email from Mark Docherty, Ambulance Commissioner at London Ambulance service to Nick turner, 1 September,2014

13. Analysed: Ambulance service performance, Health Service Journal, December 2012

14. Urgent and emergency services - Health Committee 2013-14, accessed from http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/17110.htm#note155

15. http://www.hscic.gov.uk/catalogue/PUB14601/ambu-serv-eng-2013-2014-rep.pdf

16. http://www.hscic.gov.uk/catalogue/PUB14601/ambu-serv-eng-2013-2014-rep.pdf

17. Analysed: Ambulance service performance, Health Service Journal, December 2012

18. HSCIC,http://www.hscic.gov.uk/article/4905/Ambulance-services-16-emergency-calls-to-999-per-minute

19. Email from Malcolm Dudlyke, Deputy Service Manager, NHS Workforce & Facilities, Health and Social Care Information Centre to Nick Turner, 28th November, 2014

20. http://www.hscic.gov.uk/catalogue/PUB14601/ambu-serv-eng-2013-2014-rep.pdf

21. Email from Ian Kay, Senior Manager, Ambulance and NHS111 data, Analytical Services (Operations), Commissioning Strategy Directorate, NHS England, to Nick Turner, 28.11.2014

22. Responses to my requests under the Freedom of Information Act (2000), March 2014

23. http://www.staffordshirenewsletter.co.uk/West-Midlands-Ambulance-Service-pressure-rising/story-21308993-detail/story.html#ixzz3BQsgU7lw

24. Owen Bennet, Daily Express, NHS horror: Heart-attack victims forced to wait FOUR hours for ambulances, 18th August,2014 accessed from http://www.express.co.uk/news/uk/500868/NHS-ambulance-scandal-as-heart-attack-victims-forced-to-wait-up-to-four-hours

25. Health Service Journal, September 2014 http://www.hsj.co.uk/hsj-local/ambulance-trusts/strained-ambulance-service-to-cut-call-outs-by-15-per-cent/5074889.article

26. The Guardian 18th September, 2014, http://www.theguardian.com/society/2014/sep/18/ambulance-queue-death-nhs-cuts

27. Oxford Mail, 9th July 2014, http://www.oxfordmail.co.uk news/11327511.Rural_areas_hit_by_a_drop_in_ambulance_response_times/?ref=rss

28. Nottingham Post, August 16th 2014, http://www.nottinghampost.com/298-wait-90-minutes-ambulance/story-22755403-detail/story.html

29. http://www.bbc.co.uk/news/health-19721977

30. http://www.monitor-nhsft.gov.uk/

31. Daily Mail, 26th November, http://www.dailymail.co.uk/news/article-101262/Scandal-hospital-patients-sent-home-sick.html

32. http://www.theguardian.com/society/2013/jul/29/nhs-111-help-line-failing-patients-investigation

33. http://www.publications.parliament.uk/pa/cm201012/cmselect/cmpubacc/1353/135305.htm

34. East Midlands Ambulance Service to cut £6.2m from budget, Grimsby Telegraph, June 06, 2014, accessed from http://www.grimsbytelegraph.co.uk/East-Midlands-Ambulance-Service-cut-6-2m-budget/story-21199615-detail/story.html

35. http://www.gmb.org.uk/newsroom/cuts-at-north-west-ambulances

36. http://www.telegraph.co.uk/news/politics/liberaldemocrats/8777446/Lib-Dem-minister-admits-wave-of-NHS-closures-coming.html

37. Email to Nick Turner from James Pavey, Senior Operations Manager, South East Coast Ambulance Service Trust, 5th September 2014

38. Hospitals (Sussex) - House of Commons - 20 June 2012, http://www.simonburnsmp.com/index.php?option=com_content&view=article&id=403:hospitals-sussex-house-of-commons-20-june-2012&catid=35:latest-speeches&Itemid=55

39. Email to Nick Turner from James Pavey, Senior Operations Manager, South East Coast Ambulance Service Trust, 5th September 2014

40. HSCIC, June 2013, Ambulance Services, England 2012-13 http://www.hscic.gov.uk/catalogue/PUB11062/ambu-serv-eng-2012-2013-rep.pdf

41. Data collated from NHS England Ambulance Quality Indicators accessed from http://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

42. Ibid. Reference 41

43. Ibid. Reference 41

44. Statistical press notice: Ambulance Quality Indicators, January 2013, https://www.gov.uk/government/news/statistical-press-notice-ambulance-quality-indicators-monthly-update-for-england--40

45. Ibid. Reference 41

46. Ibid. Reference 41

47. HSCIC Data on Written Complaints in the NHS, 2013-14

http://www.hscic.gov.uk/catalogue/PUB14705/data-writ-comp-nhs-2013-2014-rep.pdf

48. Response to my request under the Freedom of Information Act (2000), March 2014

49. NWAS Quality reports 2011-2014

50. Response to my requests under the Freedom of Information Act (2000), March 2014

51. http://www.bbc.co.uk/news/uk-england-london-13051798

52. Charlie Cooper, Health Correspondent, Government told to invest in ambulance services as complaints soar, The Independent, 28th, August 2014

53. Response to my request under the Freedom of Information Act (2000), March 2014

54. Response to my request under the Freedom of Information Act (2000), March 2014

55. Charlie Cooper, Health Correspondent, Government told to invest in ambulance services as complaints soar, The Independent, 28th, August 2014

56. Email to Nick Turner from James Pavey, Senior Operations Manager, South East Coast Ambulance Service Trust, 5th September 2014

57. Unite Health Pay and Terms Survey 2013

58. E. O'Flynn, 'Lives at risk' as ambulance service plans £13.8 million cuts, Bolton News 28th may 2014 accessed from http://www.theboltonnews.co.uk/news/11238942._Lives_at_risk__as_ambulance_service_plans___13_8_million_cuts/

59. East Midlands Ambulance Service to cut £6.2m from budget, Grimsby Telegraph, June 06, 2014, accessed from http://www.grimsbytelegraph.co.uk/East-Midlands-Ambulance-Service-cut-6-2m-budget/story-21199615-detail/story.html

60. www.theguardian.com, Tuesday 12 April 2011

61. Daily Mirror, 26th April 2014

62. Email to Nick Turner from James Pavey, Senior Operations Manager, South East Coast Ambulance Service Trust, 5th September 2014

63. http://www.nhscareers.nhs.uk/explore-by-career/ambulance-service-team/careers-in-the ambulance-service/

64. Ibid. Reference 64

65. Response to my requests under the Freedom of Information Act (2000), March 2014, from East of England Ambulance Service NHS Trust

66. Telephone conversation between Mark Docherty, Ambulance Commissioner at London Ambu-lance Service and Nick turner, 18th September 2014

67. http://www.nhscareers.nhs.uk/explore-by-career/ambulance-service-team/careers-in-the ambulance-service/

68. http://www.secamb.nhs.uk/get_involved/working_for_us/job_types.aspx

69. http://www.nhscareers.nhs.uk/explore-by-career/ambulance-service-team/careers-in-the-ambulance-service/senior-paramedic/

70. Health Professions Council (2009), Education factsheet - Paramedics, Specialist Paramedics, http://www.collegeofparamedics.co.uk/downloads/HPC_Factsheet_on_Paramedics_doc_Sept_09.docx

71. http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.asp

72. L. Soo, D. Gray, T. Young, N Huff, A Skene, and J. Hampton, Resuscitation from out-of-hospital cardiac arrest: is survival dependent on who is available at the scene?, Heart. Jan 1999; 81(1): 47–52.

73. D. L. Isenberg and R. Bissell (2005), Does Advanced Life Support Provide Benefits to Patients?: A Literature Review, Prehospital and Disaster Medicine / Volume 20 / Issue 04 / August, pp 265-270

74. M.S.Eisenberg, B.T.Horwood, R.O. Cummins, R. Reynolds-Haertle and T.R. Hearne (1990), Cardiac arrest and resuscitation: a tale of 29 cities, Ann Emerg Med. Feb;19(2):179-86

75. N. Samaras, T. Chevalley, D. Samaras, et al. Older patients in the emergency department: a review. Ann Emerg Med 2010; 56: 261-269; C. Colwell, P .Murphy, T. Bryan (2006, Geriatric Trauma, accessed from http://www.emsworld.com/article/10322468/geriatric-trauma.

76. Response to my requests under the Freedom of Information Act (2000), March

77. Data collated from NHS England Ambulance Quality Indicators accessed from http://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

78. Survey of Unite members, June 2014

79. Ibid. Reference 79

80. Ibid. Reference 79

81. Select Committee meeting on Urgent and Emergency Services 2013-14, para. 136, accessed from http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/17110.htm#note160

82. Email from Mark Docherty, Ambulance Commissioner at London Ambulance Service to Nick turner, 18th September 2014

83. Ibid. Reference 83

84. Ibid. Reference 83

85. Ibid. Reference 83

86. Ibid. Reference 83

87. Email to Nick Turner from James Pavey, Senior Operations Manager, South East Coast Ambulance Service Trust, 5th September 2014

88. Care Quality Commission (2014), National findings from the 2013/2014 Ambulance survey of 'Hear and Treat' callers, accessed from http://www.cqc.org.uk/sites/default/files/20140707%20Amb13%20national%20summary%20final.docx

89. http://www.nhscareers.nhs.uk/explore-by-career/ambulance-service-team/careers-in-the-ambulance-service/emergency-medical-dispatchercall-handler

90. Joint Royal Colleges Ambulance Liaison Committee guidelines. Section on Drugs, p.333

91. Letter from Paul Sutton , Chief Executive, South East Coast Ambulance Service NHS Trust, to Nick Turner, 18th December 2013

92. Ibid. Reference 83

93. Response to my FOI request by North East Ambulance Service Trust, March 2014

94. Reply to my request under the Freedom of Information Act (2000) from North West Ambulance Service NHS Trust, March 2014

95. Survey of Unite members June 2014

96. South East Coast Ambulance Service Trust Bulletin, Issue No: 410,15 May 2014, p.4

97. Letter from James Pavey, Senior Operations Manager, South East Coast Ambulance Service NHS Trust, to Nick Turner, 30th June 2014

98. Letter from James Pavey, Senior Operations Manager, South East Coast Ambulance Service NHS Trust, to Nick Turner, 17th February 2014

99. Strategic Plan Document for 2013-14, South Western Ambulance Service NHS Foundation Trust http://www.swast.nhs.uk/Downloads/SWASFT%20downloads/AnnualPlan1314_1516.pdf

100. NHS (2013), Tackling Demand Together, accessed from http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106924.pdf

101. S. Calkin, Ambulance services eye savings by sending fewer ambulances, HSJ 26 April, 2011, accessed from http://www.hsj.co.uk/sarah-calkin/1201086.contributor

102. NHS (2013), Tackling Demand Together, P.15, accessed from http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106924.pdf

103. West Midlands Ambulance Service NHS Foundation Trust, Report to the Board of Directors, Agenda Item 10, paper number 06, May 2013, Strategic Forward Plan 2013-14, accessed from http://www.wmas.nhs.uk/Documents/Board%20201305%20-%20Paper%2006%20Strategic%20Forward%20Plan.pdf

104. https://www.gov.uk/government/news/acting-fast-proves-it-can-save-hundreds-of-lives

105. The Welcome Trust blog Focus on Stroke, 10 May, 2012, http://blog.wellcome.ac.uk/2012/05/10/focus-on-stroke-making-a-campaign-out-of-a-crisis/

106. http://www.telegraph.co.uk/health/healthnews/7530895/Ambulance-service-gets-38-for-every-patient-they-dont-take-to-hospital.html

107. Care Quality Commission (2014), National findings from the 2013/2014 Ambulance survey of 'Hear and Treat' callers, accessed from http://www.cqc.org.uk/sites/default/files/20140707%20Amb13%20national%20summary%20final.docx

108. Department of Health (2012), Transforming NHS Ambulance Services, HC 1086 SESSION 2010–2012 10 JUNE, accessed from: 2011http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&cad=rja&uact=8&ved=0CEsQFjAG&url=http%3A%2F%2Fwww.nao.org.uk%2Fwp-content%2Fuploads%2F2011%2F06%2Fn10121086.pdf&ei=8ibvU-uUOOeI7Abbu4DIDQ&usg=AFQjCNHINIzv-uoYw3cQV8PcN13zXcVTSw

109. Urgent and emergency services - Health Committee, 24th July 2013, para.132, http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/17110.htm

110. http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/06/Ambulance-Systems-Indicators-February-2013-14-Revised-02.05.20141.xls

111. Hundreds may have died in 999 ambulance blunder, Laura Donnelly, Sunday Telegraph, Mar 2010, accessed from http://www.telegraph.co.uk/health/healthnews/7489663/Hundreds-may-have-died-in-999-ambulance-blunder.html

112. South East Coast Ambulance Service NHS Foundation Trust Board Report, NHS Pathways Triage System, Post Implementation Report – 1 year on December 2012

113. West Midlands Ambulance Service NHS Foundation Trust, Report to the Board of Directors, Agenda Item 10, paper number 06, May 2013, Strategic Forward Plan 2013-14, p.7, accessed from http://www.wmas.nhs.uk/Documents/Board%20201305%20-%20Paper%2006%20Strategic%20Forward%20Plan.pdf

114. South East Coast Ambulance Service NHS Foundation Trust Board Report, NHS Pathways Triage System, Post Implementation Report – 1 year on December 2013, p.2

115. Unite Health Pay and Terms Survey 2013

116. Survey of Unite members, June 2014

117. http://www.itv.com/news/calendar/update/2014-05-17/ambulance-workers-to-walk-out/

118. http://www.unitetheunion.org/news/new-strike-ballot-for-yorkshire-ambulance-staff-in-patient-safety-dispute/

119. Bespoke data from IDS survey, of ambulance staff on behalf of Unite the Union

120. Survey of Unite members, June 2014

121. Care Quality Commission 2014, A Fresh Start for the Regulation of Ambulance Services

122. Response to my requests under the Freedom of Information Act (2000), March 2014

123. Response to my requests under the Freedom of Information Act (2000), April 2015

124. Response to my requests under the Freedom of Information Act (2000), March 2014

125. Response to my requests under the Freedom of Information Act (2000), March 2014

126. Response to my requests under the Freedom of Information Act (2000), March 2014

127. Response to my requests under the Freedom of Information Act (2000), March 2014

128. UK-Exeter: Ambulance services, 2013/S 039-062495 Contract notice, accessed from http://ted.europa.eu/udl?uri=TED:NOTICE:62495-2013:TEXT:EN:HTML

129. Response to my requests under the Freedom of Information Act (2000), March 2014

130. Response to my requests under the Freedom of Information Act (2000), March 2014

131. Response to my request under the Freedom of Information Act (2000), February 2014

132. Response to my requests under the Freedom of Information Act (2000), March 2014

133. Survey of Unite members, June 2014

134. Daily Mirror 22nd April, 2014

135. Response to my requests under the Freedom of Information Act (2000), March 2014

136. Care Quality Commission 2014, A Fresh Start for the Regulation of Ambulance Services, p.21

137. Quoted in A. Jashapara, Clinical Innovation in pre-hospital care: An introduction to Critical Care Paramedics in the United Kingdom, Royal Holloway .University of London.

138. Response to my requests under the Freedom of Information Act (2000), March 2014

139. Response to my requests under the Freedom of Information Act (2000), March 2014

140. Response to my requests under the Freedom of Information Act (2000), March 2014

141. Response to my request under the Freedom of Information Act (2000), March 2014

142. Response to my requests under the Freedom of Information Act (2000), March 2014

143. Response to my requests under the Freedom of Information Act (2000), March 2014

144. Response to my requests under the Freedom of Information Act (2000), March 2014

145. Council of Governors meeting of South East Coast Ambulance Service NHS Foundation Trust, 30 July 2012

146. Survey of Unite Members, June 2014

147. Ibid. Reference 150

148. Laura Donnelly, NHS spending doubles on private ambulances used for 999 calls, The Telegraph, 9th April, 20014.

149. Council of Governors meeting of South East Coast Ambulance Service NHS Foundation Trust, 30 July 2012

150. East of England Ambulance Service NHS Trust Board Meeting, January 2014

151. East Midlands Ambulance Service NHS Trust, Board of Directors meeting, January 2014

152. Peter Blackburn, EMAS spending £7m on private ambulances due to lack of staff, Nottingham Post, March 20, 2014

153. http://www.southcentralambulance.nhs.uk/_assets/publications/annual%20plan/scas-strategic-plan-13-14.pdf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SUPPORT
FEDERATION
www.nhscampaign.org
www.nhsforsale.info