NEWS RELEASE

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New report focuses on recommendations to make ambulance transfers safer

A new report published today shows that a lack of national guidance and standard practice for ambulance transfers could be putting patients at risk.

The report from the Healthcare Safety Investigation Branch (HSIB) puts forward key recommendations aimed at making transfers safer for adults that are critically ill.

An investigation was launched after the HSIB was notified of the case of Richard, a 54-year old man, who died during an emergency transfer to a specialist care centre. He had been diagnosed with an acute aortic dissection after experiencing chest pain during exercise earlier that day.

The investigation found that there is variance of care in emergency transfers due to a lack of national guidance. Although guidance is in place for planned transfers, it is complex and not always standardised across networks. It also found that the pre-alert process (where the ambulance crew phones ahead to prepare the hospital) is inconsistent in terms of length, the volume and order of information and who delivers that information.

The report sets out two recommendations:

- The Department for Health and Social Care (DHSC) coordinates the development of national guidance, with the Arm's Length Bodies, for the transfer of critically ill adults, both in planned and emergency situations.
- The Association of Ambulance Chief Executives (AACE) works with partners to define best practice standards for the criteria, format, delivery and receipt of ambulance service pre-alerts.

Keith Conradi, Chief Investigator said: "*This investigation covered a complex case that involved a long transfer and multiple trusts. However, it was clear that many of*

the factors in the case also had wider implications for the healthcare system and that there was more that could be done at a national level.

"The findings highlighted that there was a varying approach to both emergency and planned transfers, and during the pre-alert process. We have recommended, to the bodies with the most influence, that consistent standards are developed to help reduce risk and improve outcomes for any critically ill adult needing to be transferred anywhere in the country".

This investigation was the first launched by HSIB. It has now been split into two parts. This report, part one, focuses on the transfer segment of the investigation. Part two, focusing on the clinical diagnosis of aortic dissection, is due in Spring 2019.

The report is now available on the HSIB website and responses to the recommendations will be published.

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Notes to Editors

- Aortic dissection occurs when the innermost layer of the wall of the aorta tears, allowing blood at high pressure to flow in between the layers forcing them apart.
- Planned transfers are regularly conducted between a local intensive care unit and a higher dependency unit at a specialist hospital.
- Emergency transfers, by definition, are conducted in a shortened timeframe where the patient needs to be transferred immediately, generally for life-saving treatment or surgery.

About HSIB

The formation of the HSIB is a world-first and represents a landmark moment for the NHS in England. HSIB's purpose is to help improve safety in the healthcare system by developing recommendations and sharing lessons from investigations. HSIB will

improve patient safety through effective and independent investigations that do not apportion blame or liability.

Media contacts

Please contact media@hsib.org.uk or phone 07710 114191 for interviews and other queries.