UK NHS Ambulance Services & Emergency Department pre-alert guideline

Release date July 2025, Review date July 2027

A pre-alert call from an ambulance clinician to a receiving hospital should only be used to communicate information about the patient that will enable the receiving Emergency Department (ED) or other clinical area to prepare a different or specialised predetermined response to support patient care on arrival.

The purpose of the pre-alert call is to allow time for the receiving hospital to:

- Prepare to provide immediate clinical interventions
- Support patient or staff safety
- Activate a specific clinical pathway that is required immediately on the patient's arrival.

A pre-alert may include a request for a specific response from the receiving hospital e.g. resus, trauma team, or immediate senior clinical review. However, the decision to implement any such response is made at the discretion of the senior clinical staff at the receiving hospital, and there may be valid reasons for them to provide an alternative response based on clinical triage and available resources in their department. Importantly, any decision to provide an alternative response to the expected pre-alert does not constitute a failure of the pre-alert call, as it is simply providing the best possible solution based on the activity within the receiving department at the time. Ambulance clinicians and ED staff should feel able to discuss this decision-making openly to share learning and encourage practice improvement.

Calls for information only (or 'heads up' calls) must be avoided as they do not lead to a specific response, add to information overload for ED teams, and may result in "pre-alert fatigue". Additional information can be immediately provided to the triage nurse on arrival to the hospital or to the receiving clinician as part of the handover.

Processes and training

Ambulance clinicians should have access to dedicated Ambulance Service remote clinical support desks, which provide advice and guidance to clinicians and help avoid overusing the pre-alert phone to the local Emergency Department.

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Both ambulance clinicians who make pre-alert calls and Emergency Department colleagues who answer pre-alert calls should receive training to ensure the pre-alert process is consistent and effective.

A pre-alert call must be clear and concise (ideally no more than 60 seconds). It must always begin with the headline concern and follow a standard, structured format that includes a brief clinical overview, clinical observations, management, and an accurate ETA.

Pre-alert calls should be made using the ATMIST format. The headline concern and ETA should be given first in case the call gets cut off. Following this, the ambulance clinician should provide the full alert message in the ATMIST format as quickly as possible and without interruption. Finally, depending on the circumstances and where feasible, the ED staff member may wish to ask additional questions to help them prepare for the patient's arrival.

Ideally, pre-alert calls should always be taken by a senior clinician within the receiving department who can implement an appropriate response to the pre-alert without seeking further senior support.

Ideally, pre-alert calls should be made on a recorded line, and it is recommended that, where this is not currently available, consideration is given to including it in organisational work plans.

Criteria for pre-alert calls to the ED

Pre-alert calls should be made according to the following criteria:

Altered physiology in adults, including any of the following:

Respiratory rate ≤8 or ≥25
O2 saturations on oxygen ≤91% (or ≤83% in patients with chronic hypercapnic respiratory failure)
Systolic blood pressure ≤90mmHg OR downward-trending systolic where symptomatic
Pulse ≤40 or ≥ 131
GCS <13 (new for patient)

Adapted from NEWS2

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Altered physiology in children as detailed in the table below:

Age	<1 year	1-4 years	5 – 12 years	13 – 15 years
RR	< 20 or >60	< 20 or >50	<15 or >40	< 10 or >30
Heart rate	< 90 or >170	< 70 or >150	< 70 or >140	< 60 or >120
Sa02	< 91 % on air			
CRT	3 or more seconds			
GCS	Modified GCS < 13	Modified GCS <13	< 13	< 13
Temperature	Age < 3months ≥38°C*			

Adapted from PEWS

Or for the following specific conditions

- Cardiac/Respiratory arrest
- Airway compromise
- Positive for Step 1 or Step 2 of the Major Trauma Triage Tool – Refer to local Major Trauma Triage tool
- ST elevation MI – follow local policies for PPCI
- Complete heart block or broad complex tachycardia with adverse features (shock, syncope, heart failure, myocardial ischaemia)
- FAST-positive stroke within the timeframe for thrombolysis
- Adults with suspected 'high risk sepsis' as per JRCALC guidelines (*see Appendix 1* or https://jrcalcplusweb.co.uk/guidelines/G0355)
- Children with 'high risk criteria' for sepsis as defined by JRCALC Guidelines – 'Children and Sepsis' criteria for ages <5, 5-11 and 12-16 years of age (https://jrcalcplusweb.co.uk/guidelines/G0355)
- Uncontrolled seizure - still fitting
- Early pregnancy emergencies, e.g. suspected ruptured ectopic, etc.
- Life-threatening asthma
- Acute behavioural disturbance
- Suspected diabetic ketoacidosis
- Uncontrolled major haemorrhage
- Overdose with abnormal physiology and possible lethality, which may require immediate intervention on arrival
- Suspected vascular emergency e.g. AAA or thoracic dissection with signs of shock, acute limb ischaemia

A pre-alert may also be activated for any rapidly deteriorating patient or where there is significant concern in the view of the ambulance clinician that the patient will require an immediate clinical intervention at the receiving department

A locally agreed emergency pathway may need to be triggered by a specific pre-alert (silver trauma pathways, for example). This will be region/hospital-specific.

The pre-hospital Maternity Decision Tool and local guidance should be used to guide conveyance and pre-alert decisions of pregnant, suspected pregnant and recently pregnant patients (within 4 weeks of pregnancy). In most circumstances, pregnant patients who are 20 weeks or more should be conveyed to maternity services (e.g. delivery suite/labour ward).

Examples of ATMIST pre-alert messages

1. Example ATMIST pre-alert for trauma

Headline concern:

"Trauma alert triggering stage 2 of the MTTT with an ETA of 1645 hrs"

A	Age and sex	45-year-old male
T	Time of injury/999 call	Approx. 4pm
M	Mechanism of injury	Motorcyclist v car
I	Injuries	Head injury, right rib fractures, tender abdomen, ?pelvic fracture, right closed femur fracture
S	Signs and symptoms	RR 20 Sa02 90% on air, 100% on 15L, P100 BP 120/64, GCS 13 E4 V4 M5 PERL size 4 BM 6.2 T35.9
T	Treatment	O2, 1g Paracetamol, 10mg Morphine, Pelvic binder, KTD, spinal immobilisation

2. Example ATMIST pre-alert for illness

Headline concern:

"Medical alert for resus please with an ETA of 11am"

A	Age and sex	79-year-old female
T	Time of onset/999 call	Woke up this morning with
M	Medical problem	SOB
I	Information related to medical problem	Known COPD, recent cough, bilateral wheeze
S	Signs and symptoms	RR 30 Sa02 70% on air – 90% on 15L, P 90 BP 150/95, GCS 15 BM 6.2 T38.2
T	Treatment	Oxygen, Salbutamol 5mg & Ipratropium 500mcg nebs, Hydrocortisone 100mg IV

Appendix 1: Adapted from JRCALC+ - ‘Adult High Risk Sepsis’

A NEWS2 score ≥5 should prompt suspicion of sepsis and urgent clinical review, but it is not diagnostic. Use alongside clinical judgment and infection history. The following markers are suggestive of “high risk sepsis” in an unwell patient, with history of infection, and indicate a time-critical emergency.

- New onset of confusion or responds only to voice or pain or is unresponsive.
- Systolic BP ≤90 mmHg (or drop ≥40 from normal) or mean arterial pressure less than 65 mmHg.
- Heart rate ≥130 per minute.
- Respiratory rate ≥25 per minute.
- Needs oxygen to keep SpO2 ≥92% (or more than 88% in known chronic obstructive pulmonary disease).
- Reduction in normal skin colour (mottled or ashen appearance; mottling may be difficult to detect in dark skin tones).
- Non-blanching rash (petechial or purpuric). For signs and symptoms of meningococcal disease, refer to Meningococcal Meningitis and Septicaemia.
- Cyanosis of skin, lips or tongue.
- Not passed urine in last 18 hours.
- Recent chemotherapy (in past 6 weeks).

*Full updated JRCALC sepsis guideline available at https://jrcalcplusweb.co.uk/guidelines/G0355