# Urgent Transport Vehicle (UTV) Policy

## Contents

## 1 Statement of Aims and Objectives

South East Coast Ambulance Service NHS Foundation Trust (the Trust) is responsible for transporting patients to definitive care as appropriate. When performing this role, not all patients are in a life-threatening condition requiring an independent clinician led emergency Double Crewed Ambulance (DCA). Many patients are assessed by a Health Care Professional and deemed to require high quality care, support and transport, delivered by trained staff.

To ensure that appropriate transportation is supplied to meet individual patient needs, the Trust will utilise Urgent Transport Vehicles (UTVs) to convey suitable patients. The use of UTV will ensure that emergency DCA vehicles are available for patients who are in a life-threatening condition and/or require clinical interventions during transportation.

All front-line operational and Emergency Operations Centre (EOC) staff must ensure they are aware of and understand this document, including its impact on the day–to-day operations of the Trust.

## 2 Principles

UTV supports the principles of the Ambulance Response Programme (ARP) which aims to allocate the most clinically appropriate response to patients to meet their individual needs. UTV improves the Trust's response to higher acuity patients by ensuring emergency resources are protected to attend life-threatening calls.
UTV crews will utilise a frontline emergency ambulance equipped as per the Trust Standard Load List.

UTVs are identified on the Computer Aided Dispatch (CAD) system in EOC by the Resource Dispatcher changing the 'resource type' to 'UTV' for the duration of the shift.

UTVs will be crewed by Emergency Care Support Workers (ECSWs) and/or Trainee Associate Ambulance Practitioners (TAAPs). At least one ECSW or TAAP on the crew must have completed a minimum of six months operational experience to be able to work together.

Paramedics, Associate Ambulance Practitioners (AAPs), and Technicians will not be routinely rostered to work on the UTVs to ensure the most efficient use of the clinical workforce.

Paramedics, Technicians and AAPs may be rostered to work on a UTV in exceptional, pre-agreed circumstances, for example, during a phased return to work, an agreed change to working pattern or a period of restriction to duties/practice. This will not change the nature of the vehicle.

The purpose of UTV is to promote high-quality, appropriate, and timely care and transport for patients who have been assessed by a Healthcare Professional (HCP) and deemed to require urgent transport to or between a healthcare facility, with no or minimal clinical interventions other than recognition of gross deterioration and Immediate Life Support (ILS) if necessary. UTV also supports patients who have been deemed as requiring unequivocal urgent transport through remote triage where a category 4 response is the selected outcome.

## 3 Model of Care

UTVs are deployed to patients who have had their care needs assessed as unlikely to deteriorate or require clinical interventions during transport.

Routine clinical observations (including 3-lead ECG monitoring where appropriate) can be undertaken whilst the patient is being transferred. UTV crews will attend to the care needs of the patient. When red flags are identified, UTV crews should manage the patient in line with their scope of practice and request clinical support.

When a UTV crew requires additional advice or support, appropriate backup should be requested via the Resource Dispatcher or clinical advice sought from the Urgent Care Hub or Critical Care Desk. UTV crews may choose to expedite transport to hospital if this will provide more timely care for their patient.

UTV crews can utilise audible/visual warning devices and exemptions for a 'blue light' transfer if this is requested by the hospital or there is unexpected deterioration during the journey.

UTV crews must operate within their scope of practice, irrespective of any request from another health care professional.

UTV transport may be requested by a HCP following a remote or face to face clinical assessment. The requesting HCP should clearly communicate a chief complaint, the patient's care needs and receiving facility when transport is requested.

The clinical care of any patient that needs transferring between facilities remains the responsibility of the hospital. Where ongoing treatment is required (for example, an infusion pump) or where there is a high risk of deterioration during transport, it is the responsibility of the hospital to provide an appropriate escort.

## 4 Deployment

### Requests from SECAmb clinicians undertaking remote clinical consultation/prioritisation

UTVs may attend any incident where an appropriately authorised SECAmb clinician has undertaken a remote clinical consultation and decided that the patient requires simple / unequivocal urgent ambulance transport, with no clinical intervention en-route. Such incidents should be downgraded to a 'Non-Emergency Ambulance Response Category 4)' disposition to indicate suitability for UTV deployment.

Clinicians undertaking clinical prioritisation of the dispatch waiting list or remote clinical assessment can consider utilising a UTV to expedite transport for patients (of any category) for whom a delay in attendance from a DCA would potentially lead to deterioration. These patients must have received a remote clinical consultation to confirm suitability of UTV transport (including a clear need for transportation communicated and agreed with the patient), with appropriate notes added to the incident instructions and CAD notes. The clinician should flag the incident to the relevant dispatcher or dispatch team leader to recommend dispatch of a nearby UTV resource.

If no outstanding work, the dispatch function should liaise with the EOC clinical function or local Urgent Care Hub to review outstanding suitable incidents which have been clinically assessed. If there are none identified, the resource should be moved from a MRC where there is already cover to the next highest point on the SSP to be available to respond to C1 confirmed or suspected cardiac arrest or unconscious noisy breathing incidents.

## Requests from clinicians on scene

**Grade 1 back up requests**
UTV resources can be deployed where the request is for additional resources, e.g. to make
up numbers at a cardiac arrest (chest compressions) or urgent transport requests e.g.
STEMI for pPCI. In these cases, there must be a Paramedic on scene, who will retain clinical
primacy and must travel with the patient if transported.

**Grade 4 - Delayed Conveyance**
(1-hour) transport requests from Health Care Professionals
(HCPs) working within the Trust, who have undertaken a face-to-face patient assessment.
This will predominantly apply to requests from Paramedics working on a Single Response
Vehicle (SRV) or Double Crewed Ambulance (DCA), however may also include other clinical
grades (NQPs, Associate Ambulance Practitioner and Ambulance Technician) with joint
decision making from a registered HCP in EOC (e.g. Clinical Supervisor, Mental Health
Practitioner or Urgent Care Practitioner) or Urgent Care Hub (e.g. Paramedic Practitioner).

**Crew Assistance**
UTVs can be deployed to provide assistance to another resource on scene. For example, to assist with a manual handling task.

## Requests from Health Care Professionals Outside SECAmb

**IFT Level 1 (IFT1) Category 1**
These requests should be triaged as a Category 1 emergency and the neareast response capable resource and transporting resource should be tasked which can include a UTV. Examples include cardiac arrests or unconscious noisy breathing incidents.

**IFT Level 2 (IFT2) Category 2**
These requests should be triaged as a Category 2 emergency and responded to with the nearest and most appropriate transporting resource which can include a UTV. This level of response is based on the clinical condition of the patient and the need for further treatment and management at the destination facility. Examples include patients going directly to theatre for immediate surgery, primary

percutaneous coronary intervention (pPCI), stroke thrombolysis and limb or sight saving surgery.

IFT Level 1 and IFT Level 2 patients although lifethreatening or time critical, these incidents can be completed by a UTV resource as it's the referring hospital who retain clinical responsibility for the patient during transfer and should therefore assess the need for and provide a suitably qualified clinical escort. SECAmb is commisioned to provide a resource to transport the patient and not paramedic or advanced interventions en route.

**HCP Level 3 (within 2-hour) and HCP Level 4 (within 4-hour) Admissions/Transports** where a community-based Health Care Professional (e.g. GP, community nurse or midwife) has assessed the patient and deemed that the patient requires urgent transport to a healthcare facility. For most cases, the booking HCP is likely to have assessed the patient face-to-face and determined that they are suitable for UTV. There may however be occasions when an HCP has not seen the patient face-to-face and has requested urgent admission/transport based on recent history and patient interactions, if this is not "as given" advise should be requested by either the Urgent Care Hub or Critical Care desk UTV Crews should not routinely challenge a HCPs decision to admit.

**All Inter-Facility Transfers between healthcare facilities.** NB - SECAmb is only commissioned to transfer patients between facilities for escalation of care., Any 'routine' patient transfers that are not for escalation of care, that require no clinical interventions or monitoring, should be undertaken by the hospitals own Patient Transport Service (PTS). Hospitals must provide an escort where intervention is beyond the scope of the crew in attendance and crew type can not be requested.

**HCP and IFT Level 3 (within 1-hour)** cases for **Mental Health Admissions/Transfers** such as Section 135, Section 2 or Section 3 where the patient is being admitted or transferred to a mental health facility.

**Routine cases** (no timeframe) – such as humanitarian assistance for patients at End-of-Life, e.g. where a patient needs moving from one room to another within their home address. Note that many routine cases will not require the patient to be transported, therefore do not constitute 'clinical care' and thus can be completed within the ECSW scope of practice (i.e. there is no referral or discharge being undertaken).

**Category 4 (C4)** non-emergency ambulance dispositions (within 3 hours) reached by an Emergency Medical Advisor (EMA) through NHS Pathways. NB - UTV resources can provide manual handling, basic interventions (such as Entonox and splinting) and transport for C4 cases.

**Rendering Aid**
UTVs may be deployed as the nearest available resource to Category 1 incidents for **confirmed or suspected cardiac arrest**. UTVs will not be used to attend other Category 1 incidents. Where a Category 1 disposition changes to a lower priority after telephone triage, the UTV must be stood down if not already arrived on scene.

## 5 Scope of Practice for Staff Working on UTVs

The Trust Scope of Practice and Clinical Standard Policy outlines the skills and interventions that staff may carry out autonomously. This authority covers the following aspects:

- Decision to undertake the skill or intervention (i.e. deciding that the patient needs to have their observations undertaken)
- Undertaking the actual skill/intervention (e.g. pulse oximetry)
- Monitoring the response to an intervention or interpreting the result of a test (e.g. utilising the patient monitor)
- Acting upon the results (e.g. administration of oxygen)

## 6 Start of Shift Procedure

UTV crews will book on-duty with EOC via the Mobile Data Terminal (MDT). The crew will contact the Resource Dispatcher (RD) for their Dispatch Desk via Airwave radio to confirm shift times and UTV status as per normal procedure.

The RD will show UTV out-of-service on the Computer Aided Dispatch (CAD) system, available for Category 1 (C1) incidents only. The RD will check for UTV incidents pending and allocate.

## 7 End of Shift Procedure

UTV resources should be returned to their own Dispatch Desk for the last two hours of their shift. Within the last two hours of shift, UTV resources can be deployed to relevant incidents within their own Dispatch Desk. Dispatch teams should work collaboratively with UTV resources and identify suitable incidents that will not knowingly contribute to a resource having a late finish. Normal end of shift arrangements will remain in place for the last one hour of the shift.

## 8 Additional Considerations

Any issues or delays regarding UTV deployment must be documented in the incident notes and a DIF-1 completed.

Only in exceptional circumstances (e.g. a declared Major Incident or Business Continuity Incident) the Strategic Commander may amend the use of UTVs.

Equipment carried on UTVs is the same as the standard load list for all DCAs. The only difference is found in the skill mix, scope and allocation of the crew. Drugs bags should be allocated to the vehicle, checked to ensure they are in date and locked in the secure cupboard at the start of the shift, following usual guidance.

## 9 Definitions

UTV - Urgent Transport Vehicle

EOC – Emergency Operations Centre

HCP – Health Care Professional

RD – Resource Dispatcher

MDT – Mobile Data Terminal

CAD – Computer Aided Dispatch

ARP – Ambulance Response Programme.

DCA – Double Crewed Ambulance

SRV – Single Response Vehicle

GP – General Practitioner

DIF-1 - Datix Incident Form

## 10 Responsibilities

- The **Chief Executive Officer** has ultimate responsibility for deployment of resources.
- The **Associate Directors of Operations** are responsible for managing this procedure.
- The **Operating Unit Managers** are responsible for implementing this procedure.
- The **Operations Managers** are responsible for monitoring and auditing this procedure.
- **Operational Tam Leaders** are responsible for local operational implementation and dissemination to clinicians.
- **EOC staff** are responsible for the day-to-day application of this policy when dispatching resources to incidents

## 11 Monitoring

East/West Operating Unit Managers will be responsible for auditing this policy, although this responsibility can be delegated to an appropriate manager at each Operating Unit.
Internal audit tools such as info.secamb and Datix will be used to ensure good utilisation and no patient safety issues have been highlighted.
Any patient safety concerns will be recorded via Datix and will be investigated by an appropriately trained investigator, with any learning outcomes shared.

## 12 Audit and Review

- Usage of UTV will be reviewed regularly by the Operations Leadership Team.
- Following the introduction of the UTV Procedure, a review will be conducted at the following frequencies with any issues highlighted and used to make any changes needed to the processes involved in their use:
- Following the first day of deployment.
- After one week of use.
- At the one-month stage.
- A formal review is to be completed at six months.
- Notwithstanding the specifics above, all policies have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.
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- Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).
- This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.
- All changes made to this policy will go through the governance route for development and approval as set out in the Policy on Policies.

## 13 Equality Analysis

The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.