SOP ID	OP005
Version	1.1 (ARP 2.2)
Title	Back-up: Management by the Clinical Hub and Ambulance Clinicians
Issued by	A&E Service Line
Approved by	Neil Le Chevalier, Director of Operations
Date Issued	25/10/2016
Review Date	25/10/2017
Directorate	Operations
Clinical Publication Category	**Protocol (Amber) - Deviation permissible if authorised by a Control officer, Duty Manager, Tactical Commander or Senior Clinician On-call**

1. Scope

1.1 This Standard Operating Procedure (SOP) covers the allocation of back-up by the Clinical Hub. The document also covers the request for, and stand down of, back-up by ambulance clinicians on-scene of an incident.

1.2 Further SOPs cover specific situations which are outside of the scope of this SOP:

- SOP C01 - Air Ambulance Attendance
- SOP C13 - Patient Support Vehicles

2. Principles

2.1 Each day within the Trust a finite number of Double Crewed Ambulances (DCAs) are available to provide back-up to Rapid Response Vehicles (RRVs). It is vital that DCAs are used carefully, to ensure that incidents requiring the most urgent back-up receive it within a timely manner, and those with far less clinical need receive it within a more appropriate timeframe.

2.2 Frontline ambulance clinicians play a key role in ensuring that back-up is available when needed, through good communication with the Clinical Hubs.

2.3 For the purposes of this SOP the term RRV refers to Rapid Response Vehicles, Motorcycle Response Units, Cycle Response Units, Responding Officers and BASICs Doctors.

3. Allocation of Back-up

3.1 Allocating back-up automatically to a wide range of conditions irrespective of the specifics of the particular incident, results in unnecessary and excessive dual responding. Keeping dual responding to a minimum, ensures that DCAs are available to be sent to patients with the highest confirmed clinical need.

3.2 Two resources must be automatically allocated to the following incidents:

- Confirmed respiratory/cardiac arrest where the death is not expected and no DNAR is believed to be in place.
- Birth imminent.
- Multiple patient incident where further resources are likely to be required, as determined by the Dispatcher.

3.3 At least one of the resources allocated must be a DCA. In the case of the DCA not being crewed by a Paramedic/Nurse, the other resource must be crewed by a Paramedic/Nurse. For example, it would be acceptable to dispatch a DCA crewed by an Advanced Technician/ECA, as long as the other resource was crewed by a Paramedic/Nurse.

3.3 A DCA will only be allocated automatically in the following situations, as either the sole response or in addition to a single responder, as a DCA remains the optimal response to:

- Category 1 calls (life threatening)
- Suspected stroke
- Suspected myocardial infarction
- Any call in Health Care premises, such as a hospital or GP Surgery, where the referring clinician has requested a conveying vehicle.
- When the Clinical Hub know, or suspect, that a patient may be exposed to the elements or in a public place and an DCA would provide shelter to carry out a clinical assessment or provide treatment.
- Dual Response recommended by the lone worker Policy
- Pre-determined response e.g. airport incident

3.4 Where a dual response is recommended by the Lone Working Policy, a second resource of any type must be dispatched where the first resource is not a DCA.

3.6 In exceptional circumstances when a single ECA or Pathway Support Vehicle (PSV) is dispatched to a confirmed Category 1 call (see SOP C09 for further guidance); the nearest DCA, RRV or Paramedic Responding Officer must be allocated to ensure qualified clinician attendance.

3.7 With the exception of the incidents already detailed, the Clinical Hub must normally deploy one resource for all other 999 calls which require a response. The focus should be on ensuring that this resource is the most clinically appropriate for the call. Further resources should normally only be deployed once a qualified clinician has arrived on scene, and based on their assessment of the situation, back up is requested in line with Section 4.

3.8 The Clinical Hub must however continue to operate in a proactive manner to ensure that back up is not unduly delayed and the quality of care provided to the patient is not compromised. In view of this, early back up should be mobilised toward a lone responder in the following circumstances:

- Any Category 1 incident where a non-Paramedic responder is due to arrive first and the patient is likely to require Paramedic intervention; e.g. suspected myocardial infarction.

- When the Call Receiver, Clinical Supervisor, Dispatcher, Control Officer, Duty Manager or responding clinician have a concern that delaying a dual response may result in the delay of on-going clinical care.

3.9 In deciding to mobilise a second resource toward the scene, the Dispatcher must take into account both the suspected clinical condition of the patient and the distance the nearest DCA will have to travel.

3.10 In these cases a crew should be mobilised towards the area whilst awaiting the responding clinicians update from scene. The crew should be advised to contact the Clinical Hub for a further update prior to approaching scene. Where appropriate this movement should be made under normal road speed conditions as a request to standby.

3.11 In all other cases, one resource will be initially allocated unless the Dispatcher, Control Officer or Duty Manager have a concern that delaying a dual response may result in the delay of ongoing clinical care.

3.12 In the exceptional circumstances where a clinician requests back-up outside of the incidents outlined in Paras 3.2, 3.4, 3.5 and 3.8 before arriving on scene with the patient, the matter must be referred to the Clinical Supervisor/Advisor within the Clinical Hub for agreement. A DATIX must be submitted by the Clinical Hub in all such cases to enable any learning to be identified which may further develop this SOP to ensure patient safety.

4. Ambulance Clinician Requests

4.1 In order to ensure that the Trust can send further resources (i.e. DCA back up) to those cases where it is clinically required with greatest urgency, it is vital that ambulance clinicians inform the Clinical Hub of the requirement for further resources at the earliest opportunity. The METHANE format may prove useful for this purpose. This is just as important when one ambulance is required to convey a patient, as it is for multiple casualty road traffic collisions.

4.2 If no further resources are required, the Clinical Hub must be informed irrespective of whether the dispatch of back-up has been discussed on or after allocation. A routine request for speech must be made, with the following message then being passed '<call sign> "no further resources required'.

4.3 On arrival at any incident where further Trust resources are required, the first resource on-scene must request routine speech with the Clinical Hub and pass the following information as soon as possible, after a swift initial assessment:

- Total number and type of resources required to include all resources already on scene and the requesting resource in the following format; "Make DCAs 2".
- Requesting in the format of "2 more ambulances are required" must not be used, as it can lead to confusion if multiple situation reports are received.
- The ambulance clinician must clearly inform the clinical hub whether back-up is required as a Priority 1, 2, 3, or 4 (see Table 1).
- Expressly inform the Clinical Hub if specific additional clinical skills are required on scene e.g. Paramedic, BASICS Doctor, HEMS (see SOP C01), HART.

4.4 Ambulance clinicians must confirm whether back-up is required on arrival at the incident.

4.5 The clinician on-scene must continue to monitor the patient. If the patient's condition deteriorates, a higher level of back-up must be requested. Similarly if a patient improves, the back-up level should be decreased accordingly.

4.6 It is the responsibility of all ambulance clinicians to ensure that each request for back-up is clinically justified. In the case of P1, the clinician must consider that there is the potential for a DCA to drive past an unconscious patient with no ambulance response on-scene, in order to provide them with the immediate back-up that they need. If the clinician would wish the ambulance to respond to the unconscious patient in preference to theirs, then a lower priority must be requested. It is absolutely not acceptable for P1 or P2 back-up requests to be placed due to end of shift issues.

4.7 Table 1 - Back-up Priority Levels

Priority	Local Response Target	Description
1	19 mins	Patient is considered time critical or requires time critical hospital intervention (e.g. PCI or stroke thrombolysis) and requires immediate additional resources responding as an emergency using blue lights and sirens. This category must only be used where clinically indicated. Example: Cardiac arrest, time critical, life-threatening, peri-arrest and myocardial infarction. P1 must be requested for all patients who meet the acute stroke pre-alert criteria (see CG20).
2	30 mins	Patient is not immediately life-threatening, but requires additional resources responding as an emergency using blue lights and sirens. Example: Fractured leg, shortness of breath.
3	40 mins	Patient is not immediately life-threatening and stable, but requires an emergency ambulance responding at normal road speed. Although a blue light response is not required, the patient would need Paramedic level skills during the transport (e.g. a PSV would not be suitable). Example: Patient who has fallen and sustained a minor injury requiring the administration of oral/IV morphine.
4	1-4 hours	The patient is safe for a 1, 2 or 4 hour HCP admission by either a DCA, PSV, private resources or PTS (where service still provided) vehicle, as detailed in Para 4.8. Example: Fall with minor or no injuries, requiring admission as the patient is unable to remain safely at home. Also patients who would be able to travel by car, but cannot do so due to reduced mobility.

5. Further Guidance on Priority 4 Back-up (Delayed Transport)

5.1 Although patients often require admission to acute Trusts or another healthcare provider, many do not require transport immediately. General Practitioners and other Healthcare Professionals (HCPs) have always operated through booking an appropriate ambulance response to suit the clinical needs of the patient; ECPs, Paramedics, Nurses and Advanced Technicians may also request ambulance transport in the same manner.

5.2 ECPs, Paramedics and Technicians may request ambulance transport within 1, 2 or 4 hours. The vehicle requested for transport may be an emergency ambulance, PSV or PTS vehicle.

5.3 A 1, 2 or 4 hour admission should be considered when the clinical assessment demonstrates that the patient is clinically stable and the patient fulfils all of the following criteria:

- Is clinically stable to remain on-scene whilst awaiting admission.
- Does not require continuing clinical interventions prior to the arrival of the admitting ambulance.
- Remains in a safe environment and is not in a public place. In some cases there may need to be a responsible adult on scene, however this is at the discretion of the senior clinician present.
- Has mental capacity and had the process fully explained, including documenting advice on the Patient Clinical Record (PCR) to call 999 if at all concerned.

5.4 When calling the Clinical Hub, please ensure that you advise that you require P4 back up, state the minimum level or resource required; Paramedic, Technician, ECA or ACA crew and whether a 1, 2 or 4 hour admission is appropriate. If a 1 hour response has been requested, but due to demand is unlikely to met, at the discretion of the Dispatcher, this may be upgraded to a P3 back-up response.

5.5 Following completion of the PCR, provided the patient can be left safely, it is expected that in the majority of cases the ambulance resource on-scene will then book clear. There is no need to remain on-scene solely to provide a handover to the receiving crew; this is provided by the PCR.

The decision to either remain on-scene or book clear rests with the senior clinician on-scene and must consider the patient's safety, medical and social needs.

5.6 Once all details relating to the back-up request have been established the Clinical Hub dispatchers should process the back-up request for the incident on CAD as per relevant local procedures and training guidance.

6. Clinical Hub Procedure for Priority 1 Back-up

6.1 A patient is considered to be time critical if they have a deficit on the primary survey (e.g. respiratory/cardiac arrest, life-threatening asthmatic in extremis and uncontrollable haemorrhage) or requires a time critical hospital intervention (e.g. PCI or stroke thrombolysis). Ambulance clinicians must carefully consider the justification for each use of the P1 category.

6.2 When an incident must be automatically allocated P1 back-up under this SOP (see Paras 3.6&7), or following receipt of a request for P1 back-up, the Clinical Hub must identify the closest appropriate resource and dispatch to scene, advising the requesting ambulance clinician of the ETA. Where a suitable resource cannot immediately be located within the timescale discussed with the requesting ambulance clinician, the Clinical Hub Dispatcher must:

- Place a group call asking for any potentially available resource to become available stating 'outstanding crew request for P1 time critical back-up'.
- Escalate the issue to the Control Officer for further support.
- Consider other suitable alternatives e.g. BASICs Doctors, Responding Officers
- Consider HEMS according to SOP C01
- Escalate the issue to the local Operational Commander if back up is not on-scene after 30 minutes from the time of the first request. If the Operational Commander is not available, the issue must be escalated to the Tactical Commander for the area.
- Escalate the issue to the Senior Clinical Advisor On-call if back up is not on-scene after 45 minutes from the time of the first request.

6.3. Guidance for Operational/Tactical Commanders

6.4 When a case requiring P1 back-up for Paramedic skills not DCA transport is escalated to the Commander, they must consider any additional steps which may be required, in extremis, to ensure the fastest possible arrival of a Paramedic. This may include calling Paramedic Staff Responders, or confirming if Paramedics already committed on vehicles within the area are able to assist.

6.3 When a case requiring P1 back-up for a conveying DCA is escalated to the Commander, they must consider any additional steps which may be required, in extremis, to ensure a DCA arrives at scene at the earliest possible opportunity.

6.4 Guidance for the Senior Clinical Advisor

6.5 The Senior Clinical Advisor must take all immediate steps to resolve the situation, which may include liaising directly with the clinician on-scene. A DATIX must be submitted in all cases.

9. Diverting Resources

9.1 The arrangements for diverting back-up resources are detailed in Table 2.

Table 2 - Diverting Resources

Priority	Divert	Communication
1	• Category 1 incident where they are the nearest resource and no other resources are already on-scene	Clinician on-scene must immediately be advised of the divert, and the next available resource must be immediately dispatched. The ETA of this resource must be provided.
2	• Category 1 • Category 2 • Priority 1 back-up request	The clinician on-scene must be advised of the divert where it is likely to impact on the arrival of back-up within the applicable local response target detailed in Para 4.7.
3	• Category 1 • Category 2 • Priority 1 back-up request • Priority 2 back-up request	As above
4	• Any call • Any back-up request	As above