CONVEYANCE POLICY

DATE APPROVED:	**12 June 2019**
APPROVED BY:	**Operational Management Team**
IMPLEMENTATION DATE:	**08 August 2019**
REVIEW DATE:	**June 2022**
LEAD DIRECTOR:	**Director of Strategic & Digital Integration**
IMPACT ASSESSMENT STATEMENT:	**No adverse Impact on Equality or Diversity**

Document Reference Number:	**Policy – 037 (Version 5.1)**

Change Control:

Document Number	Policy – 037
Document	Conveyance Policy
Version	5.1
Owner	Director of Strategic & Digital Integration
Distribution list	All
Issue Date	June 2019
Next Review Date	June 2022
Author	Lead Paramedic

Change History:

Date	Change	Authorised by
	Initial Draft	Clinical Policies Lead & General Manager BBC
14 June 2011	No changes – approved	Clinical Governance Committee
20 June 2011	No changes – approved	Staff Side Policy Group
16 December 2014	No changes agreed to extend twelve months	Operational Management Board
31 March 2016	Change to Emergency Services Director title	Emergency Services Director
04 April 2016	Agreed	Operational Management Team
09 June 2016	Minor changes made – agreed document	Policy Group
06 July 2016	Sent to for information	Regional Partnership Forum
May 2019	Reviewed – update re job titles and corporate identity	Lead Paramedic for Emergency Care
12 June 2019	Approved	Operational Management Team
04 July 19	Agreed minor changes	Policy Group
07 August 2019	Agreed	Regional Partnership Forum
November 2019	Section 8.4 added around guidance for seatbelts and harnesses	Lead Paramedic – Emergency Care
10 December 2019	Group declined document and requested appropriate representation to the Group	Policy Group
11 December 2019	Approved addition to document.	Operational Management Team
17 January 2020	Discussions around the added section iro seatbelts and harnesses. Agreed for immediate implementation.	Policy Group
11 March 2020	Sent for info only	Regional Partnership Forum

CONTENTS

1 Statement

West Midlands Ambulance Service University NHS Foundation Trust (the Trust) is committed to the active management of risk. This Document has been developed to ensure all patients are provided with safe appropriate health care at an appropriate health care facility following full assessment by a Trust clinician. This policy covers the special arrangements for transport for specific patient groups so that the patient is conveyed to the most appropriate place of care for their clinical condition. This includes details of procedures where a patient bypasses the local hospital and is transported to another hospital for more appropriate or specialist care.

2 Introduction and Scope

The Trust objectives are to provide high quality, clinically effective patient care using Trust resources efficiently and expediently.

This document should be read in conjunction with the policies/procedures listed at the end of this policy.

The key objectives of the policies covered in this document are:

- To ensure all patients receive high quality care by a suitably qualified clinician where appropriate.
- To ensure that no patients are abandoned or left without care or access to care.
- To ensure compliance to the Care Quality Commission (CQC) and the NHS Constitution
- To ensure WMAS achieves its strategic goals

3 Definitions

The definitions of groups of people for the purpose of this policy are as follows:

Clinician – A health care professional (HCP) involved in the assessment or care of a patient to include the following:

- **Doctor** – A medical practitioner registered with the General Medical Council (GMC).
- **Critical Care Practitioner (CCP)** – A HCP (a Paramedic in this instance) who has undergone further specialist training in pre hospital care, anaesthesia and rapid sequence induction (RSI). This is a non-exhaustive list.
- **First Contact Practitioner (FCP)** - A HCP (a Paramedic in this instance) who has undergone further specialist training in patient assessment and the use of the medical model for recording patient history and clerking.

- **Advanced Paramedic** – A Paramedic who has undertaken the same training as an FCP but with the addition of minor wound closure to include gluing and steristripping.
- **Paramedic** – A HCPC registered with the Health Care Professions Council (HCPC) and practicing within the scope of the Association of Ambulance Chief Executives (AACE) Clinical Guidelines and the National Institute for Health and Clinical Excellence guidelines (NICE).
- Student Paramedic – An employee who is undertaking the Ambulance Associate Practioners programme or equivalent regulated qualification.
- **Nurse** – A HCPC registered with the Nursing and Midwifery Council (NMC).
- **IHCD / or equivalent Technicians** – Ambulance personnel who have completed an Institute of Health and Care Development (IHCD) course (or equivalent).
- **Emergency Care Assistants** – (ECA's) Ambulance personnel who have completed an Institute of Health and Care Development (IHCD) course.
- **Patient Transport Services**
- **Computer Aided Dispatch System (CAD)** – Command and Control software utilised within the Emergency Operations Centre.
- **Integrated Emergency & Urgent Operations Centre (ICU)** – Sites where 999/111 calls are received and processed.
- **Clinical Support Desk (CSD)** – A team working within the ICU providing secondary triage to certain category C calls and advice to ICU and road staff.
- **Strategic Capacity Cell (SCC)** – A team working within the ICU providing support to clinicians on scene in relation to alternative pathways and destination choices.

4 Accountabilities and Responsibilities

4.1 The **Trust Board** are responsible for the effectiveness of this policy and procedures and for ensuring sufficient resources are available to support the implementation.

Where it is not possible to address certain risks the Trust Board has ultimate responsibility for the acceptability of those risks

4.2 The **Quality Governance Committee** is responsible for the approval and monitoring of the policy.

4.3 The **Medical Director** is the nominated Executive Director with lead responsibility for managing the strategic development and implementation of clinical risk management, including clinical governance and effectiveness.

4.4 The **Director of Human Resources and Operational Development** is responsible for ensuring that appropriately trained individuals provide training in accordance with WMAS training needs analysis.

4.5 The **Director of Strategic & Digital Integration** is responsible for ensuring that there is sufficient risk management in place for the management of patients. They must also ensure that responsibilities are effectively devolved throughout the organisation and that effective and timely briefing, training and guidance is given to support this.

4.6 The **Integrated Emergency & Urgent Care (ICU) Director** will have a responsibility for:

- Ensuring ICU staff understands the contents of this policy and the associated documents.
- Ensure all appropriate staff receives the necessary training.

4.7 All Trust staff involved in the care and or transportation of patients have a responsibility to:

- Make themselves aware of the contents of this policy and associated procedures.
- Must follow the policy as laid out by the Trust.
- Attend mandatory training.
- It is the responsibility of all staff to identify risks and highlight these to an appropriate manager, usually through the Incident Reporting Policy procedure (ER-54).

5 Risk Assessment of This Policy

5.1 Formal written risk assessment of the Policy will be assessed using the Trust Risk Matrix as per the Risk Management Strategy, and Risk Assessment Policy and procedures available from the Trust Website. This will be undertaken by the Operational Management Team.

5.2 Strategic and organisational risk assessments are placed on the Trust's Risk Register. The Risk Register is reviewed by the Health, Safety Risk & Environment Group; high risks are monitored by Executive Management Board. Adverse incidents will be monitored by the Professional Standards Group.

6 Competence (Education and Training)

6.1 All staff involved in the care and or transportation of patients within the Trust must ensure that they can work to the standards as set out by UK Ambulance Service Clinical Practice Guidelines, the scope of practice of their professional body and within the scope of the Trust's local policies.

All clinicians employed by the Trust must ensure that they are up to date with current clinical practice.

Trust staff are reminded that registered health care professionals have a responsibility to maintain their knowledge and skills in accordance with their registered body's Policy:

- Doctors - General Medical Council
- Paramedics - Health Care Professions Council
- Nurses - Nursing and Midwifery Council

Clinicians who feel that their knowledge and skills fall below the expected competencies should in the first instance contact their line manager.

6.2 The Education and Professional Development Department will facilitate education and training for clinical staff.

6.3 The Trust, as part of its ongoing process, will develop a Training Needs Analysis (TNA) which identifies statutory and mandatory training. This training may be in a variety of formats (e.g. in-house, external, work-based, briefing, e-learning etc.).

The Trust's TNA for Statutory and Mandatory Training is the source document for stating what the Trust regards as Statutory and Mandatory Training, the groups of staff affected, and the frequency of the training. This TNA is reviewed and updated annually. Each year the Trust agrees and publishes an annual training plan against this TNA

7 Monitoring Compliance and Effectiveness

7.1 A review of the policies effectiveness will be undertaken by the Director of Strategic & Digital Integration 6 months after the implementation of the policy.

7.2 The monitoring of compliance with this Policy will be undertaken by the Clinical Audit Team within 3 months of its review date by checking:

- Compliance with training needs analysis
- Clinical Managers have completed audits

Compliance outcomes will be reported to the Strategic Operations Director.

7.3 A sample of Patient Records (exact amount to be determined by the Clinical Audit Team) will be audited at least annually for compliance. The results of which will be reported to the Strategic Operations Director.

8 Transportation of Patients

8.1 The destination of the patient must be determined using criteria based upon clinical needs. Attending staff must make a full assessment of the patient before determining where the patient will be taken. Guidance on the decision of destination will be from the UK ambulance service clinical practice guidelines. Staff should consider the clinical needs of the patient, the facilities available at local hospitals and the local pathway agreements. Where a designated destination has been provided, the patient must be conveyed to the precise destination stated upon receipt of the call details. Should subsequent assessment reveal a change in treatment priorities, the initial destination may be revised in the best interests of the patient.

Palliative care patients may have a designated destination such as a hospice-this should be taken into account and contact made with the hospice or palliative care team about appropriate destination if the patient's condition is not time critical.

Patients attended as the result of emergency calls where conveyance is deemed necessary, should be conveyed to the nearest appropriate health care facility. There are certain exceptions to this:

- Where the nearest/local Emergency Department does not receive a certain category of patient these patients must be conveyed to the next appropriate Emergency Department.
- Where the nearest/local Emergency Department has an agreed divert in place and the patient is not critically unwell may be diverted to a different hospital and this will be coordinated by the hospital desk and SCC.
- When the condition of the patient suggests that rapid access to specialist care will require that they be directly conveyed to a hospital providing that speciality (refer to local pathways via CSD or the SCC).

A doctor or other health care professional (HCP) with responsibility for the patient may make a request for the patient to be taken to a designated destination other than the nearest Emergency Department. Staff should comply with the request, if the facility has accepted the patient.

Should the patient refuse to travel or it is deemed appropriate to non-transport or refer the patient to another health care professional then this should be in line with the Non-transport and Referral Policy.

8.2 Removal From Scene

Staff should refer to the Trusts Safer Manual Handling Policy for guidance on how to remove the patient from scene to a conveying vehicle.

Staff must ensure that all reasonable efforts are made to protect the privacy, confidentiality and dignity of their patients.

Non-emergency patients who are required on clinical grounds to stay in their wheelchairs during conveyance will only be conveyed in an appropriate vehicle with floor clamps and a safety harness used to secure the patient.

8.3 Escorts

The decision as to whether/how many friends/relatives travel with the patient rests with the crew, predominantly though with the driver and patient and must be based upon both the patient's needs and the practicalities of the patient's treatment.

Where possible, patients below the age of 18 should be accompanied by a parent or guardian. When this is not possible, a teacher or other responsible adult can accompany the patient in loco parentis, or, the attending clinician will act in loco parentis until this responsibility is passed to the person receiving the patient.

8.4 Use of Seatbelts and Safety Harnesses

All staff MUST comply with the legal requirement for all persons travelling in ALL Trust vehicles to be secured using the seatbelts or where applicable, safety harnesses provided. In order to give maximum protection to patient and escorts whilst on Service vehicles, every effort must be made to persuade them to use a seat restraint. Patients and escorts who decline the offer should have their attention drawn to any notice displayed. If they still decline,a reference to this must be recorded on the PRF/EPR and where possible a signature should be obtained.

Stretcher patients should be secured onto the stretcher using the safety harness provided, unless the medical condition dictates otherwise. Safety harnesses must not be removed from stretchers. Staff should check to ensure that stretchers have them attached when doing the vehicle / equipment check.

The responsibility for ensuring that a child under the age of 16 (as per the Road Safety Act 2006) is restrained in the back of an ambulance (where it is possible to do so) rests with the driver. The Ambulance Child Restraint (ACR) must be used and further guidance on this can be sourced from the Paediatric Care Policy.

Passengers seated on standard seats have a 3-point harness to use. Passengers in wheelchairs may have an additional 3-point harness or a lap belt. If fitted, it should be used. A major safety issue is the need to ensure that the lap belt portion of the 3-point harness crosses over the body as close to the hips as possible.

Passengers MUST also be seated in the forward facing near side passenger seats and secured at all times whilst the vehicle is in motion. Passengers must remain seated and with their seatbelt worn correctly whilst the vehicle is in motion. The definition of a 'passenger' is any individual who are not involved in the active participation of patient management for example, emergency services workers, prison officers (this list is not exhaustive). The only contra-indicator for this is if the patient's condition dictates otherwise, This encompasses "all" Staff, Students and other Observers (Trust, University and Other Emergency Services & Escorts)

8.4 En Route

In the event that a patient is in the care of the service and is deemed critically ill it is expected that the member of staff who is most appropriately trained to deliver extended skills will travel with the patient on the journey to hospital. If a number of health care professionals are escorting the patient, the attendant may travel in the front of the ambulance but must be prepared to assist the escorting team if required.

8.5 Upon Arrival/Handover

A verbal handover should be given to the receiving member of staff followed by written / electronic patient report form including all relevant clinical and assessment information.

If a discharged patient has been conveyed home, but there is, in the professional opinion of the crew, an inadequate level of support to maintain the patient's welfare, the crew should inform ICU/NEOC before potentially returning the patient to the hospital. The department the patient was collected from should be contacted for appropriate arrangements to be made for the patient, with the responsibility for the patient resting with the facility that the patient came from.

8.6 Major Incidents
In the event of a major incident, the conveyance of patients will be conducted as set out in the casualty regulation plan contained within the Trusts Major Incident Plan.

9 Patient Groups

9.1 Patients are categorised by age into the following definitions by the United Kingdom Resuscitation Council (UKRC) in relation to resuscitation guidelines;

- Adults are defined as patients from 16 years + of age
- Children are defined as patients from 1 year to 16 years of age
- Infants are defined as patients aged Birth to 1 year

9.2 Patients are also categorised by their presenting medical condition into:

- Trauma patients are defined as those with injury or shock to the body from violence or accident.
- Medical patients are defined as those with a disease or illness.
- Mental health patients are defined as those with psychological or behavioural pattern associated with distress or disability that occurs in an individual that is not part of their normal development or culture.
- Patients with a disability - Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives. (World Health Organisation 2010(WHO)).

10 High Risk Patient Groups

10.1 Patients suffering from any disease that affects cognitive function including patients with Learning Difficulties, Dementia or any disease which may affect a person's capacity to consent, should be considered a 'high risk' patient group.

10.2 All callers/patients should be deemed to have the capacity to consent unless assessed otherwise. Some of these patients may lack capacity to consent under the WMAS Consent Policy and a referral to the safeguarding team as per the Safeguarding Children Young People and Adults at Risk Policy and Procedure may be appropriate. Guidance may be sought from the clinician within the ICU.

11 Documentation

11.1 Appropriate notes **MUST** be added to the PRF/EPR as per the Trust Patient Clinical Records Policy and Procedures.

12 Equality and Diversity Statement

12.1 This policy embraces Diversity, Dignity and Inclusion in line with emerging Human Rights guidance. We recognise, acknowledge and value difference across all people and their backgrounds. We will treat everyone with courtesy and consideration and ensure that no-one is belittled, excluded or disadvantaged in anyway shape or form.

12.2 A full Equality Impact Assessment (EIA) screening tool has been completed in relation to this policy.

12.3 The EIA highlighted no negative impacts for any patient groups covered by this policy.

13 Implementation Plan

13.1 The Strategic Operations Director will be responsible for implementing and distributing this Policy.

13.2 The Policy will be made available to all operational staff in the Trust. The policy will also be posted on the Trust intranet site.

14 Policy Review

14.1 A review of the policies effectiveness will be undertaken by the Medical Director 3 months after implementation. This will ensure the policy is robust.

14.2 This policy will be reviewed in 2 years from the date of approval.

15 References

- WMAS Risk Management Strategy
- WMAS Health and Safety Policy
- WMAS Incident Reporting Policy
- WMAS Patient Clinical Record Policy and Procedure
- WMAS Paediatric Care Policy
- WMAS Consent Policy
- WMAS Safeguarding Children and Vulnerable Adults Policy and Procedure
- WMAS Safer Manual Handling Policy
- WMAS Major Incident Plan
- World Health Organisation 2010
- Department of Health - The Caldicott Committee Report on the Review of Patient Identifiable Information.
- The General Data Protection Regulations 2016 and the Data Protection Act 2018