Clinical Standard Operating Procedure (SOP)

TRANSFER RISK ASSESSMENT AND ESCORTS

SETTING	Service-wide
FOR STAFF	All Retrieve staff and referring hospital clinicians
PATIENTS	All patients

Introduction

Retrieve's objective is to deliver high quality, safe, efficient and equitable critical care transfer. As Adult Critical Care Transfer Services (ACCTS) have re-shaped the transfer landscape across the United Kingdom, challenges have arisen within services and between service users, particularly around standards and expectations. The most commonly questioned area concerns risk assessment and clinical escorts for patients. This document provides information and clarity in this area for both Retrieve team members and service users.

Critical care transfer and national guidelines

The Intensive Care Society (ICS) and other national bodies have published guidance concerning critical care transfer for almost 30 years and the most recent editions of the ICS guidelines and Guidelines for the Provision of Critical Care Services (GPICS) will be published in 2025. Both documents recognise the significant changes that have occurred since the pandemic and emphasise that the same high standards of critical care must be provided regardless of type of transfer, urgency or transferring team. With reference to risk assessment and clinical escorts, there are several key standards that are relevant to this document.

GPICS version 3

- A risk assessment must be undertaken and used to determine the required competencies, seniority and experience of the transferring team.
- All clinical team members involved in transfer must be trained in critical care transfer and be sufficiently competent, experienced and current to jointly manage the patient, anticipated events during transfer, unexpected emergency situations and to operate all transfer equipment competently and safely.

ICS guidelines 2025

- All acute hospitals must have systems and resources in place to resuscitate, stabilise and transfer critically ill patients 24 hours a day, 7 days a week, when required. These should align with ACCTS and NHS Ambulance Service provision of transfer.
- Regions and Critical Care Networks should continue to work collaboratively with ACCTS to deliver 24/7/365 services that are equitable, efficient and appropriately meet geographical and patient pathways.
- Acute hospitals must plan for, and continue to provide, critical care transfer of patients 24 hours a day in the event that the ACCTS is committed or unavailable.
- Critically ill patients requiring transfer are often complex and at risk of deterioration or unexpected change in condition. They should normally be accompanied by two suitably trained, competent and experienced clinical escort during any transfer. The formation of the escorting

team and required competencies will depend on the nature of the underlying pathology, co-morbidities, level of dependency and risk of deterioration during transfer.

- Risk assessment should take into account a number of factors including clinical condition, transfer risks, likelihood of deterioration, potential for requiring additional interventions and other factors. In addition, the experienced clinician undertaking the risk assessment may need to consider factors such as acute hospital operational pressures, other patients requiring transfer and other interventions. Careful consideration should be given to balancing these global risks with those posed by, and to, the patient.
- In certain circumstances, low risk patients may be accompanied by one clinical escort such as a nurse or other registered practitioner. However, their ability to safely deal with unexpected emergencies must be considered as management of these situations almost always requires at least two clinicians.
- Higher risk patients always require two clinical escorts with resuscitation and critical care competencies including advanced airway skills. These escorts may be physicians, Advanced Critical Care Practitioners (ACCPs), nurses and other registered practitioners experienced in the management of critically ill patients and critical care transfer equipment in hospital. Commonly the two escorts are a physician plus nurse or ACCP plus nurse.
- NHS Ambulance Service crew are not suitable as the second clinical escort as they are not experienced in the use of critical care transfer equipment or management of critically ill patients in hospital.

Retrieve's approach

We have created a risk assessment (Appendix 1) and list of commonly encountered scenarios where clinical escorts are requested (Appendix 2). Several key principles underpin Retrieve's approach to these:

- Team and patient safety during transfer in our ambulances is paramount.
- Staffing:
  - A fully staffed Retrieve rota with Duty Consultant, Transfer Doctor and Transfer Practitioners across the Peninsula and Severn bases is essential.
  - We acknowledge that this has been the hardest single element of the ACCTS Service Specification to achieve since launch and is by far the greatest source of frustration when working with service users. Complete rota coverage in a sustainable and resilient way requires all South West Critical Care Network hospitals to work collaboratively with Retrieve as it is impossible to deliver this in any other way.
  - Transfer Practitioners are highly skilled critical care nurses. When they deploy without a Duty Consultant or Transfer Doctor, they are usually accompanied by a non-clinical driver (unlike NHS Ambulance Services). Given the patient population Retrieve is commissioned to transfer, it is rarely suitable or safe for us to transfer a patient with the single medical professional on board the ambulance. Occasionally, we will undertake low risk transfers (see below) when there are two Transfer Practitioners present.
- We have adopted a balanced-risk approach aimed at maximising team and patient safety as well as ensuring as many patients receive our expert care as possible.
- The Retrieve risk assessment and clinical escort requirements are closely aligned with the Intensive Care Society's 2025 guidelines.

- We are publishing our risk assessment and clinical escort guidance to ensure transparency and consistency of application.
- Risk assessment completion and outcome must be documented on ARCEMS for each transfer where a full Retrieve team is not available.

Risk assessment in practice

- **Duty Consultant** coordinating the referral: complete risk assessment using clinical information received during referral. This process is essential in Retrieve understanding and documenting the risk we hold in undertaking the transfer. Communicate this with Transfer Practitioner and referring hospital clinician. Note that the outcome of this assessment is based on the information provided and, occasionally, the patient may deteriorate or in-person assessment identify additional factors which may change the risk profile of the transfer.
- **Transfer Practitioner** follow Transfer Practitioners Operations SOP and remain in regular contact with Duty Consultant. Bedside conversation with Duty Consultant to ensure risk assessment correct and accompanying clinician appropriate.
- **Referring hospital** liaise with Duty Consultant regarding patient clinical condition, available escorts as well as other factors that may need to be considered.

Differences of opinion

In recent discussions with referring hospitals and the wider SWCCN, it is clear that there are three main sources of disagreement when it comes to the outcome of risk assessment and requirement for clinical escort:

- Different perceptions of risk (e.g. 'well-looking' low-grade subarachnoid haemorrhage and acute aortic dissection patients).
- Challenges balancing Retrieve risk assessment with other operational risks within the referring hospital including availability of staff, concurrent clinical requirements, etc.
- Application of different standards for a Retrieve transfer compared with referring hospital transfer with South Western Ambulance Service NHS Foundation Trust (e.g. Retrieve require clinical escort to accompany Transfer Practitioner vs calling 999 and sending patient without an escort as SWASFT do not clinically triage case).

We acknowledge that none of these situations are straightforward to resolve. From a patient perspective, it is important to emphasise that Retrieve's approach is based on the principles described above and the standards that are now expected for critical care transfer.

Principles for resolving differences of opinion

- Retrieve will apply this risk assessment consistently and transparently, hence the creation and sharing of this document.
- The majority of disagreements will be successfully resolved with respectful and pragmatic discussions involving both referring hospital clinician(s) and Retrieve.
- We encourage senior referring hospital clinician involvement and welcome direct referral and discussion with our Duty Consultant team.

- Where the outcome of the risk assessment is that the patient is moderate or high risk (requires a medical escort) and the referring clinician disagrees, Retrieve will:
  - Not deploy if this is apparent in the initial referral call.
  - Stand down and return to base if this arises when the team are already at the bedside.
- In these situations, Retrieve will not arrange a SWASFT 999 ambulance. The referring clinician will have to do so as they, and their Trust, will be taking on the risk associated with their decision.

Feedback, reporting and monitoring

We encourage referring and receiving hospitals to continue to provide feedback through existing channels. Direct contact with Retrieve can be achieved by using our Single Point of Contact (SPOC) email address which is monitored routinely during working hours: Retrieve.Transfer@nhs.net.

Retrieve clinical team: please document in full, flag on ARCEMS and incident report disagreements that result in us not deploying or standing down at the bedside.

We will monitor the application and impact of this risk assessment as well as any reported incidents and will work to provide additional information online to support referring hospital conversations (e.g. case vignettes, data on number and frequency of cases where deterioration and/or harm occurs to help those who see these types of patients less frequently better understand the reasons for our application of these standards).

Document Change Control

Date of Version	Version Number	Lead for Revisions	Type of Revision	Description of Revision
07/2025	1.0	Clinical Director	New document	

Document Governance

REFERENCES	1. Guidelines for the Provision of Intensive Care Services (GPICS), version 3, 2025. Pre-publication, accessed June 2025. 2. Intensive Care Society Guidance on: transfer of the critically ill adult 2025. Pre-publication, accessed June 2025.
RELATED DOCUMENTS AND PAGES	• Transfer Practitioner Operations SOP • Duty Consultant Operations SOP
AUTHORISING BODY	UHBW Division of Surgery CQOG & South West Critical Care Network Board
SAFETY	
QUERIES AND CONTACT	Retrieve Leadership Team

Appendix 1 – Risk assessment

Duty Consultant to complete whenever a full Retrieve team (Duty Consultant or Transfer Doctor + Transfer Practitioner) is not available. If a patient parameter falls across risk categories, choose higher category. Completion should be timely and must not delay deployment or transfer.

Low risk

Maintaining airway FiO_2 <0.4 No vasopressor support GCS 14-15 (stable for at least 60 mins prior to transfer) Base deficit 0 to -4mmol/L Normothermic NEWS2 1-4	Single Retrieve Transfer Practitioner, Transfer Doctor or Duty Consultant

Low risk with additional complexity

Maintaining airway FiO_2 <0.4 No vasopressor support GCS 14-15 (stable for at least 60 mins prior to transfer) Base deficit 0 to -4mmol/L Normothermic High task load due to clinical condition or additional monitoring requirements Mild delirium NEWS2 1-4 Transfers >90mins in estimated duration	One Retrieve Transfer Practitioner, Transfer Doctor, Duty Consultant **PLUS** Second Retrieve Transfer Practitioner **OR** Appropriate Healthcare Professional e.g. Nurse, HCA, Midwife, Perfusionist

Medium risk

Maintaining airway FiO_2 <0.6 Low-dose vasopressor support / BP manipulation GCS 9-13 (consider intubation) Base deficit -4 to -8mmol/L Mild hypo-/hyperthermia Physiological instability prior to transfer Moderate to severe delirium or agitation Low to moderate risk of deterioration en-route (low grade SAH, AAD, TTP, posterior circulation stroke, etc) Requires, or may require, additional interventions en-route (e.g. transfusion) NEWS2 5-6	Retrieve Transfer Practitioner(s) **PLUS** Doctor or ACCP with critical care and advanced airway competencies Retrieve Transfer Doctor or Duty Consultant **PLUS** Doctor/ACCP/Nurse/ODP with critical care skills

High risk

Intubated/tracheostomy FiO_2 >0.6 Higher dose vasopressor support / BP manipulation Cardiovascular instability Base deficit worse than -8mmol/L Moderate to high likelihood of deterioration en-route Requires, or may require, additional interventions en-route (e.g. airway management) NEWS2 ≥7 Aeromedical transfer	Retrieve Transfer Practitioner(s) **PLUS** Doctor or ACCP with critical care and advanced airway competencies Retrieve Transfer Doctor or Duty Consultant **PLUS** Doctor/ACCP/Nurse/ODP with critical care skills

Appendix 2 – When is a clinical escort required?

In developing this document and refining the risk assessment provided by the ICS, we have used our experience over the last 4 years to provide clinical examples of the different types of patients described above in each risk level. Referring hospitals are only asked to assist and provide a clinical escort when Retrieve does not arrive with a full team (Duty Consultant or Transfer Doctor + Transfer Practitioner). The same institutions may also find this helpful for scenarios when Retrieve is unavailable (e.g. committed elsewhere) and the transfer is being completed with SWASFT.

The majority of patients require two clinicians, one of whom has advanced airway competencies (thus is a doctor or ACCP). These include, but are not limited to:

High risk:

- Subarachnoid haemorrhage ≥Grade 2 (SOP)
- Polytrauma with organ support requirements (e.g. intubated)
- Traumatic brain injury
- Stroke thrombectomy deemed high risk (altered GCS, seizures, posterior fossa, etc) (SOP)
- Acute intracerebral haemorrhage
- Severe acute respiratory failure

Medium risk:

- Acute (≤48h) Grade 1 subarachnoid haemorrhage patients (SOP)
- Acute aortic dissection (SOP)
- Polytrauma
- Urosepsis requiring nephrostomy insertion
- Bleeding patient requiring interventional radiology
- NIV/CPAP transfers (SOP)
- Ventilated/tracheostomy repatriation patients
- Patient with IABP or Impella device

Occasionally, the service transfers low risk patients who do not necessarily require a doctor or ACCP with advanced airway skills. Some of these patients have additional complexity and so meet the standard described above in needing two clinicians, and a small number are suitable for a single clinician (e.g. Transfer Practitioner):

Low risk with additional complexity

- Stable patient with ongoing blood transfusion or drug infusion.
- Ward level repatriation of continuation of care from ICU-high care/ward area who is delirious.

Low risk

- Ward level repatriation or continuation of care from ICU-high care/ward area (e.g. acute stroke repatriation post-thrombectomy with no critical care requirements).