



# OPERATIONS POLICY & PROCEDURE (OPS No.11)

## MULTIPLE OPERATIONAL RESOURCE ON SCENE PROCEDURE

DOCUMENT INFORMATION	
<b>Author:</b> Deb Ingram, Clinical Operations Manager, South	<b>Consultation &amp; Approval:</b> Staff Consultation Process (21 Days) from 07.03.2012 Governance Committee Board Ratification if Appropriate
<b>This document replaces:</b> New procedure and guidance	<b>Notification of Procedure Release:</b> Staff Notice Boards SCAS internet & Intranet Staff E-mail
<b>Equality Impact Assessment</b>	Stage 1 Assessment undertaken – no issues identified
<b>Date of Issue:</b>	November 2018
<b>Next Review:</b>	November 2020
<b>Version: 2</b>	<b>Version 4</b>

## INDEX

	<b><u>PAGE</u></b>
1. Purpose	3
2. Scope	3
3. Duties	3-4
4. Procedure Background Information	4
5. Procedure	4-6
6. Monitoring	7
7. Review	7
8. Equality & Human Rights Impact Statement	7
9. Reference & Reading	8
10. Equality Impact Assessment	9

## MULTIPLE AMBULANCE RESOURCE ON SCENE PROCEDURE

### 1.0 PURPOSE

- 1.1 The purpose of this procedure is to provide Operational and Emergency Operations Centre (EOC) staff with guidance to achieve a reduction, where clinically safe to do so, in the amount of time multiple operational responses are at scene together. This will release operational resources to improve patient care as well as improving operational performance.

### 2.0 SCOPE

- 2.1 This procedure applies to all South Central Ambulance Service NHS Trust (SCAS) Clinical and EOC staff including Operational Managers, Specialist Paramedics (SP), Paramedics, Trainee Associate Ambulance Practitioners (TAP), Associate Ambulance Practitioner (AAP), Emergency Care Assistants, Technicians, Ambulance Nurses, HART Operatives, BASiCs Practitioners and Clinical Support Desk Clinicians.

### 3.0 DUTIES

- 3.1 It is the responsibility of all clinical staff to follow the guidance outlined within this procedure. If a prolonged period of time (20 minutes plus) is going to be spent at scene by a multiple resource that will not be conveying a patient, then the EOC should be informed with the reason for this and an estimated time when that resource will become available. At very busy times EOC may ask the resource to leave the scene to attend an emergency if it is safe clinically to do so.
- 3.2 **Chief Operating Officer** has Board level responsibility for the review and implementation of operational procedure and guidance within South Central Ambulance Service NHS Trust.
- 3.3 **Operations Directors and Assistant Director of EOC** have delegated responsibility for managing the strategic development and implementation of clinical and non-clinical operational policies and should apply this procedure throughout the Trust ensuring it is available to staff and adhered to.
- 3.4 **Head of Operations and EOCs** will be responsible to the Operations Directors and Assistant Director for EOC for the development of effective Trust wide policies and procedures. Specific responsibilities will include monitoring compliance of this procedure and the performance management of staff.
- 3.5 **Clinical Operational Managers and Control Managers** are responsible for implementing this procedure within the operational environment. They report to the Head of Operations /EOC and should make this procedure available to all staff within their departments. Clinical Operation Managers and Control Managers should read and fully understand this procedure with specific responsibility for monitoring all areas of this procedure and the performance management of staff against the procedure.
- 3.6 **All Operational and EOC Staff** are required to read and adhere to this procedure when attending a scene with multiple resources in attendance. If a prolonged period of time is going to be spent at scene by multiple resources that will not be conveying a patient, then the EOC should be informed with the reason for this and an estimated time when that resource will become available.

- 3.7 This applies to all SCAS clinical staff including Operational Managers, EOC staff, Trainee Associate Ambulance Practitioners (TAP), Associate Ambulance Practitioner (AAP) Emergency Care Assistants (ECA), Technicians, Paramedics, Specialist Paramedics(SP), Ambulance Nurses, HART Operatives, BASiCs Practitioners and Clinical Support Desk Clinicians.

#### **4.0 PROCEDURE BACKGROUND INFORMATION**

- 4.1 The Trust has been looking at various ways of improving patient care and operational performance within its existing operational resources. An audit of statistical information highlighted differences between Areas across the Trust in relation to the amount of time multiple operational resources were on scene without conveying a patient.
- 4.2 A review of Trust policies highlighted a need for guidance to both clinical and EOC staff regarding good practice when multiple operational resources were at the scene of an emergency incident.
- 4.3 The benefits of reducing the time that multiple resources are at scene are:
- 4.3.1 Quality of patient care improved by releasing ambulance/solo response vehicle (RRV) resource earlier to attend further deployments, therefore reducing the amount of time patients have to wait for an ambulance resource.
  - 4.3.2 Reduction in the amount of overruns and meal breaks missed at busy times.
  - 4.3.3 Increase in operational performance by increasing the amount of resources available.
- 4.4 The Trust recognises that there are always occasions that require an operational resource that will not convey a patient, providing assistance at a scene. This procedure is intended to give guidance to operational crews and EOC staff to manage this in the most effective way to optimise patient care.

#### **5.0 PROCEDURE**

- 5.1 The purpose of this procedure is to provide Operational and Emergency Operations Centre (EOC) staff with clinically safe guidance to achieve a reduction on the number of occasions and in the amount of time multiple operational resources spend 'on scene'. This will release operational resources to improve both patient care and operational performance, whilst improving the efficiency of our resource management.

This procedure links to the EOC Standing Operational Procedures for the dispatch of 'back up' to Rapid Response vehicles. Automatic 'back up' must be sent for RRVs for the following event types:

- Adult and Paediatric Cardiac arrests
- Chest pain of possible cardiac origin
- Acute Stroke Symptoms
- Acute neurological Symptoms
- Meningitis Symptoms
- Obstetric Emergencies
- Acute respiratory distress
- Fitting continuously (status Epilepticus) or

- First fit & still fitting at the time of the call
- Unconscious
- Significant Trauma
  - Gunshot/stab wounds to head /neck/torso
  - Drowning
  - Electrocution
  - Hanging
  - High speed motorcyclist/cyclist collisions
- RTC
  - Patient Trapped
  - Patient Ejected from vehicle
  - High Mechanism Crashes
  - Pedestrian hit at 20mph or more

Consideration should also be given to the skill mix attending the patient in case Paramedic skills are required at the scene.

**For all other incidents the EOC will wait for an update from the responding RRV to request a transporting vehicle.**

- 5.2 SP/RRV - Once they have completed their clinical assessment and are happy that they do not require an additional operational resource they should contact EOC at the earliest opportunity and inform them that they do not require additional backup.

If back up is required, then a status request should be sent from the Tetra hand portable to request back up. This should be confirmed through verbal communication with EOC to confirm the type of response and clinical level required (i.e. Clinical or DECA crew).

If an immediate response is required due to the patients presenting condition being time critical EOC must be informed immediately. EOC will then allocate the next closest resource to the incident.

- 5.3 Operational Staff who will not be conveying a patient or treating the patient at the scene should book 'clear' and become available as soon as it is clinically safe to do so.
- 5.4 If multiple resources are attending a patient then the first operational resource on scene should complete the relevant sections of the Patient Care Record (PCR)/ Electronic Patient Report form (EPR), if appropriate, identifying any observations or treatments they have undertaken prior to booking clear.

When the second or conveying resource is allocated the call, the Patient Record will be transferred or be available to be accessed, by this resource to update and complete en-route to the relevant Treatment Centre. The clinical handover must be completed as efficiently as possible to allow the release of the first resource on scene.

- 5.5 If a prolonged period of time (20 minutes after the second ambulance response has arrived) is going to be spent at scene by a multiple operational resource which will not be conveying a patient, then the EOC **must** be informed with the reason for this and an estimated time when that resource will become available. This information should be recorded within the CAD Incident Record.

- 5.6 **Parking at Scene:** It has become apparent that on a number of occasions

the RRV/ECP/DCA on scene has been blocked in by the second resource thereby preventing the first resource from leaving the scene.

Care should be taken to avoid blocking in any operational resource if feasible to do so, thus allowing the DCA/RRV to book clear and leave the scene for further deployments without delay.

- 5.7 **Ambulance Equipment:** If the patient's condition allows, the first on scene vehicle should contact EOC with the specific ambulance equipment (including specialist resource, i.e. bariatric, HART, required to manage the patient/s. This will be passed to the supporting resource. Alternatively, EOC can provide the supporting vehicle with the call sign and ISSI number of the attending vehicle to facilitate communication via Tetra.
- 5.8 The second attending resource, whether DCA/RRV, should attend the patient with their requested equipment so allowing the first response to exchange equipment and restock and book available once a patient handover has taken place.
- 5.9 **Specialist Paramedic (SP) Called:** Under normal circumstances all calls that the crew believe are suitable for an SP should be passed to the Clinical Support Desk (CSD) for consideration if available. If the CSD clinician deems that the call is appropriate, then the crew should clear ASAP. A full clinical handover should be passed to the CSD Clinician, if appropriate then the crew leaving the scene can contact the responding SP and give them a clinical handover.

This should be completed through a recorded line or via phone patch from the CSD/EOC. It is vital that a correctly filled EPR is available for the attending Specialist Paramedic.

- 5.10 If the patient's clinical condition requires the operational crew to stay at scene until the SP arrives, the EOC must be informed and the reasons for the crew to stay at scene entered into the CAD Patient Record. As soon as the SP arrives, a patient handover will take place and agreement reached regarding transportation. If not required, the operational crew should book available immediately.
- 5.11 **Additional Paramedic/SP/Band 4 Clinician travels to hospital:** There are occasions on clinical grounds for additional operational staff are required to travel with the patient to Hospital Emergency Departments, either as support or as the lead clinician. In this situation the clinician must travel with the ambulance and not follow behind in their vehicle if additional clinical support is required.

5.11.1 It is suggested that the least clinical member to drive the RRV/DCA to hospital under normal road conditions, not using Emergency audible/visual warning devices.

5.11.2 If a vehicle is left on scene because additional assistance is required in the rear of the ambulance, the following will apply:

EOC must be informed and confirm that the ambulance can take the single person back to their vehicle.

EOC should consider arranging for a Team Leader, Officer/Manager to return the staff member back to their vehicle. If the journey time exceeds 15 minutes, especially during periods of high demand. This will allow the DCA to be deployed when it comes available.

- 5.12 **HIOWAA & TVCAAT Helicopters:** The senior clinician on the aircraft, where the patient's condition allows, can stand-down operational resources/BASICs etc. (To be reviewed in line with progression of this resource)
- 5.13 **EOC: Multiple Patients Incidents:** Will monitor the amount of time that multiple resources are on scene. If the EOC does not receive an **ETHANE** update from the scene of a multiple resourced incident within 10 minutes of the time the second resource arrived on scene, they should contact the crews concerned and ask for an update. EOC should record all reasons for prolonged double resourcing at scene in the CAD Patient/Incident record.
- 5.14 The EOC should send a Team Leader or Manager to all emergency incidents where more than four DCA/RRV resources have been asked to attend. A management resource should also be sent to any receiving hospital with more than three ambulances from the same incident. This is to support ambulance crews at scene and to assist in a smooth turn around at hospital.

## **6.0 MONITORING**

- 6.1 The monitoring of this procedure will be through the Area Performance Management Framework at levels 1, 2 and 3.
- 6.2 The Operations Directors will be jointly responsible to delegate a Head of Operations to carry out a yearly review of this procedure and will provide a report to the Performance Management Group (level 3) and the Operational Procedure Review Group which will include:-
- 6.2.1 Review of the procedure to see that it is still current and does not need updating.
  - 6.2.2 Statistical data of compliance at Station and Divisional level.
  - 6.2.3 Number of Datix relating to the procedure
  - 6.2.4 Number of disciplinary issues relating to non-compliance of the procedure.
- 6.3 Any action plans developed to improve this procedure will be monitored by the Performance Management Framework at levels 1, 2 and 3 for effectiveness.

## **7.0 REVIEW**

- 7.1 This procedure will be reviewed on an annual basis or sooner in the light of any changes in guidance and guidelines to which the Trust must adhere.

## **8.0 EQUALITY & HUMAN RIGHTS IMPACT STATEMENT**

- 8.1 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marital status, disability, race, nationality, gender, religion, sexual orientation, gender reassignment, ethnic or national origin, beliefs, domestic circumstances, social and employment status, political affiliation or trade union membership, HIV status or any other basis not justified by law or relevant to the requirements of the post.
- 8.2 By committing to a procedure encouraging equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills,

knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

- 8.3 The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of race, ethnic or national origin, colour or nationality; gender (including marital status); age; disability; sexual orientation; religion or belief; length of service, whether full or part-time or employed under a permanent or a fixed-term contract or any other irrelevant factor.
- 8.4 Where there are barriers to understanding e.g. an employee has difficulty in reading or writing or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the Human Resource Department

## **9.0 REFERENCE & READING**

- Risk Management Strategy
- Adverse Incident and Reporting & Investigation Procedure
- Patient Clinical Records Procedure
- Emergency Care Practitioners Procedure
- Care Pathway Procedure
- Control Standing Operational Procedures
- JRCALC Guidelines
- Trust Job Description
- Trust's Transport of Patients by Solo Response Vehicles
- EOC immediate RRV back up procedure



# Equality Impact Assessment Form: Section One – Screening

Name of Function, Procedure or Strategy:.....~~Multiple Resources on Scene~~.....

Officer completing assessment: ..... Neil Cook .....

Telephone: .....

<b>1. What is the main purpose of the strategy, function or procedure?</b>
The procedure is designed to reduce the number of resources on the scene at incidents to facilitate a speedy response back available and to increase the time available to respond to further calls
<b>2. List the main activities of the function or procedure.</b>
Provide guidance to operational and EOC staff on the process of attending incidents and then clearing at the scene of incidents
<b>3. Who will be the main beneficiaries of the strategy/function/procedure?</b>
All managers and employees of the Trust and all patients
<b>4. Use the table overleaf to indicate the following:</b>
a. Where do you think that the strategy/function/procedure could have an adverse impact on any equality group; i.e., it could disadvantage them?
b. Where do you think that there could be a positive impact on any of the groups or contribute to promoting equality, equal opportunities or improving relations within equality target groups?

Protected Characteristic		Positive Impact	Negative Impact	Reasons for impact
<b>GENDER</b>	Women	N/A	N/A	
	Men	N/A	N/A	
	Asian or Asian British people	N/A	N/A	
<b>RACE</b>	Black or Black British people	N/A	N/A	}
	Chinese people and other people	N/A	N/A	
	People of Mixed Race	N/A	N/A	
	White (inc Irish) people	N/A	N/A	
	Disabled People	N/A	Yes	Possible learning difficulties and problems with understanding
	Lesbians, gay men and bisexuals	N/A	N/A	
<b>AGE</b>	Older People (60+)	N/A	N/A	
	Younger People (17 to 25) and children	N/A	N/A	
	Faith Groups	N/A	N/A	
	Equal Opportunities and/or improved relations	N/A	N/A	Yes – ensuring that a fair and consistent process is followed for all Trust staff.

**Notes:**

Faith groups cover a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and to the needs of other communities that do not appear as separate categories in the Census, for example, Polish.



**5. If you have indicated that there is a negative impact, is that impact:**

	Yes	No
<b>Legal</b> <i>(it is not discriminatory under anti-discriminatory law)</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Intended</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Level of Impact**

If the negative impact is possibly discriminatory and not Intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

High	Low
<input type="checkbox"/>	<input checked="" type="checkbox"/>

**6a) Could you minimise or remove any negative impact that is of low significance? Explain how below:**

Clear, simple language used. Line managers support and guide their staff to understand what has been written in the procedure and the impact/effect it would have on them.

**6b) Could you improve the strategy, function or procedure positive impact? Explain how below:**

N/A

**7. If there is no evidence that the strategy, function or procedure promotes equality, equal opportunities or improves relations – could it be adopted so it does? How?**

N/A

**Please sign and date this form, keep one copy and send one copy to the Trust's Equality Lead.**

**Signed:** ..... **Neil Cook** .....

**Name:** ..... **Neil Cook** .....

**Date:** ..... **7<sup>th</sup> November 2018** .....

# Equality Impact Assessment Form Section Two: Full Assessment

Name of Function, Procedure or Strategy: Multiple Resources on Scene

Officer completing assessment: Neil Cook

Telephone: .....

## Part A

- Looking back at section one of the EIA, in what areas are there concerns that the strategy, procedure or project could have a negative impact?

Gender	N/A
Race	N/A
Disability	N/A
Sexuality	N/A
Age	N/A
Faith	N/A

- Summarise the likely negative impacts:-

.....

.....

- Using the table below, give a summary of what previous or planned consultation on this topic, procedure, function or strategy has or will take place with groups or individuals from the equality target groups and what it noted about the likely negative impact?

Equality Target Groups	Summary of consultation planned or taken place
Gender	None .
Race	As above
Disability	As above
Sexuality/Transgender	N/A

Equality Target Groups	Summary of consultation planned or taken place
Older People	N/A
Younger People	N/A
Faith	N/A

4. What consultation has taken place or is planned with Trust staff including staff that have or will have direct experience of implementing the strategy, procedure or function?

..... Standard 21-day consultation with all staff is planned prior to procedure being approved and.....  
 ..... signed off.....  
 .....

5. Check that any research, reports, studies concerning the equality target groups and the likely impact have been used to plan the project and guide or indicate what research you intend to carry out:-

Equality Target Groups	Title / type of / details of research/report
Gender	
Race	
Disability	
Sexuality/Trans sexuality	
Older People	
Younger People	
Faith	

6. If there are gaps in your previous or planned consultation and research, are there any experts/relevant groups that can be contacted to get further views or evidence on the issues?

Yes (Please list them and explain how you will obtain their views)

.....  
 .....

No

**Part B**

Complete this section when consultation and research has been carried out

7a. As a result of this assessment and available evidence collected, including consultation, state whether there will be a need to be any changes made/planned to the procedure, strategy or function.

7b. As a result of this assessment and available evidence, is it important that the Trust commissions specific research on this issue or carries out monitoring/data collection?

*(You may want to add this information directly on to the action plan at the end of this assessment form)*

.....  
.....  
.....

8. Will the changes planned ensure that negative impact is:

Legal?   
(not discriminatory, under anti-discriminatory legislation)

Intended?

Low impact?

9a. Have you set up a monitoring/evaluation/review process to check the successful implementation of the strategy, function or procedure?

Yes  No

9b. How will this monitoring/evaluation further assess the impact on the equality target groups/ensure that the strategy/procedure/function is non-discriminatory?

Details:

.....  
.....  
.....

**Please complete the action plan below, sign the EIA, retain a copy and send a copy of the full EIA and Action Plan to the Trust’s Equality Lead.**

**Signed:** Neil Cook

**Name:** Neil Cook

**Date:** 11<sup>th</sup> June 2015

# EIA ACTION PLAN

Issue	Action Required	Lead Officer	Timescale	Resource Implications	Comments

*Please continue on another sheet if you need to.*