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**AMBULANCE**  
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# National framework for inter-facility transfers

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Differences between this document and the previous version – published July 2019 – are highlighted in **yellow**.

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# 1. Introduction

This framework is intended for patients who require transfer by ambulance between facilities due to an increase in either their medical or nursing care need. The aim of this framework is to ensure:

- equity of access for all seriously ill or injured patients
- recognition that in certain situations, immediate clinical assistance to make a life-saving intervention may be required, in addition to ambulance transportation
- consistent definitions for high acuity inter-facility transfer (IFT) responses are established and are mapped to ambulance response programme (ARP) response priorities Category 1 and Category 2
- opportunity for local innovation and acknowledgement of different contractual and commissioning arrangements for lower acuity incidents
- activity and response to IFT incidents can be measured separately to other 999 activity in order to examine parity of response.

The definition of a facility, to which this framework applies, is all healthcare facilities that provide inpatient services. In some locally determined situations, an additional 'facility' will be defined by the ambulance trust as suitable to use the IFT process – ie urgent treatment centres or other type 3 and 4 services with direct admitting rights to inpatient services.

Patients who have immediate life-threatening injuries or illnesses should be transferred, where necessary with an appropriate hospital escort, and within a set timeframe mapped to ARP categories as described below.

Similarly, patients with serious or urgent healthcare needs should be transferred in an appropriately commissioned timeframe. Local systems should have commissioned arrangements in place for the return of personnel and equipment to facilities.

The following framework should be used so that individual systems can develop standard operating procedures and decision algorithms. Requests must be based on the clinical need of the patient and not based on other issues such as capacity and flow challenges or availability of hospital staff escorts, etc.

## 2. Inter-facility transfer levels

A set of IFT levels are described in this framework with a clear definition of the patient groups that are allocated to each level. These levels are mapped to the current ARP categories and ambulance trusts are expected to respond to these requests in the same way and timeframe as other 999 calls in that category.

There are four levels of IFT response:

### **IFT Level 1 (IFT1) Category 1**

This level of response should be reserved for those exceptional circumstances when a facility is unable to provide immediate life-saving clinical intervention such as resuscitation or in the case of a declared obstetric emergency and requires the clinical assistance of the ambulance trust in addition to a transporting resource.

These requests should be processed through the trust's 999 triage tool and only those that are deemed a Category 1 under that assessment should receive a Category 1 response. Examples would include cardiac arrest, anaphylaxis, birth units requiring immediate assistance or acute severe life-threatening asthma in an urgent care facility.

**While these calls may be flagged within the trust computer aided dispatch (CAD) system as being an IFT response (for ambulance quality indicator [AQI] reporting purposes), they must be presented and displayed in the trust CAD system in the same way as Category 1 calls from the public and responded to accordingly.**

### **IFT Level 2 (IFT2) Category 2**

This level of response is based on the clinical condition of the patient and the need, or a high likelihood of the need, for further treatment and management at the destination facility rather than the patient's diagnosis.

Immediate life, limb or sight (globe trauma) threatening (ILT) situations that require immediate management in another healthcare facility should receive this level of response. Other examples include patients going directly to theatre for immediate neurosurgery, primary percutaneous coronary intervention, stroke thrombolysis, **mechanical thrombectomy**, surgery for ruptured aortic aneurysm, emergency

laparotomy, surgery for ectopic pregnancy, limb or sight saving surgery or mental health patients being actively restrained.

**While these calls may be flagged within the trust CAD system as being an IFT response (for AQI reporting purposes), they must be presented and displayed in the trust CAD system in the same way as Category 2 calls from the public and responded to accordingly.**

These IFT level 2 patients are mapped to a Category 2 response. A specific set of interventions, as detailed above, should be strictly adhered to.

IFT Level 1 and Level 2 incidents are confirmed emergencies which require life-saving intervention and should be responded to as time critical emergencies and immediately allocated the nearest appropriate response.

If an ambulance is not immediately available for dispatch to an IFT **Level 1 or 2 call** this incident should be escalated within the ambulance operations centre to ensure an appropriate response.

In the case of an IFT Level 1 incident, ambulance trusts should consider whether the request requires a solo responder in addition to an emergency ambulance (ie where the closest resource is a solo responder or the closest emergency ambulance crew are not a Paramedic crew).

There should be little or no variation in the proportions of the above categories across England.

### **IFT Level 3 (IFT3) Locally Determined Response**

This level may be commissioned for patients who do not require immediate life or limb saving interventions but require an increase in their level of clinical care as an emergency. Where this is commissioned a set timeframe for the level of response should be specified between 30 minutes and two hours.

This level of response may include mental health crisis transfers or those solely for the purpose of creating a critical care bed.

### IFT Level 4 (IFT4) locally determined response

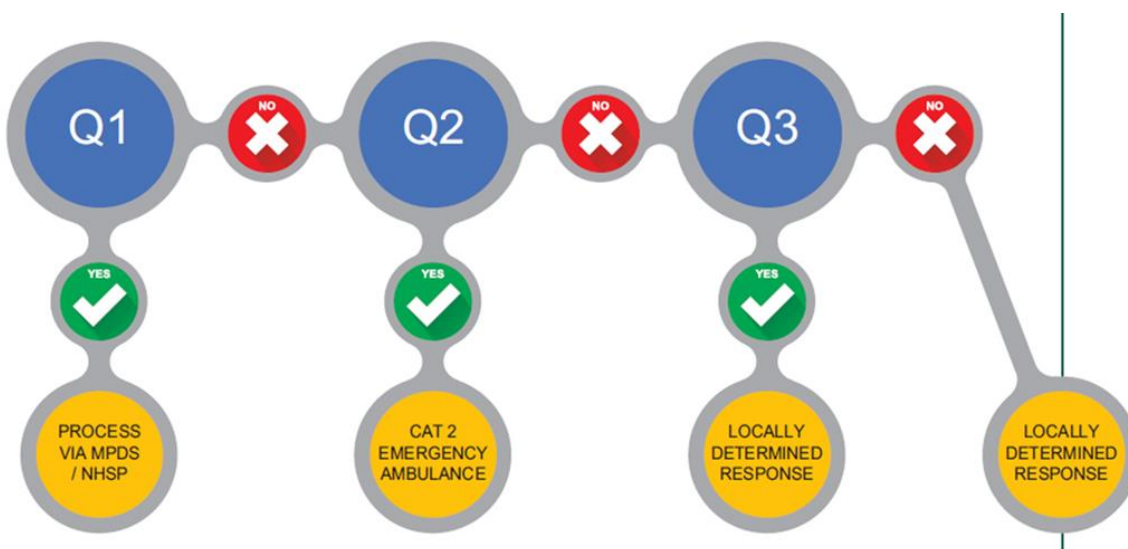
This is for all other patients who do not fit the above definitions and require urgent transport for ongoing care but do not need to be managed as an emergency transfer. Patients being transferred to inpatient wards for ongoing management or for elective and semi elective procedures or investigations would be included in this group. This category of patient will have a timeframe outside of the ARP standards and will be determined through their normal commissioning arrangements.

Patients who do not fit the definitions above are not appropriate for an IFT Level 1, 2 or 3 response from the ambulance trust. In some cases, patients with immediate life or limb threatening conditions may not be ready for transfer within the IFT Level 1 or 2 timeframe and require further management before being clinically suitable for transfer. In this instance, a lower IFT level of response will be allocated to reflect the time delay until the patient is ready for transfer.

Repatriations or step-down transfers/discharges to non-hospital facilities and outpatient appointments are not intended to be included in the IFT framework.

## 3. Process flow chart

A nature of call option 'IFT' should be in operation in all ambulance trusts to operate this framework.



The clinical staff responsible for the patient determine that transfer to another healthcare facility is clinically necessary. It is the responsibility of requesting clinicians to ensure that this protocol is applied correctly. Inappropriately requesting an IFT Level 1 or 2 transfer for patients who do not require immediate life or limb saving clinical intervention is a serious breach of protocol which should be reviewed by ambulance trusts in conjunction with the requesting healthcare facility.

Where immediate ambulance clinical support and/or transportation is requested by a facility it is the responsibility of the clinical staff responsible for the patient to make the request to the ambulance trust. It is highly desirable that, if possible, the clinician should not delegate this responsibility as experience has shown that a clear transfer of all information is needed.

Where delegation is unavoidable the individual making the request for support should be able to answer triage questions about the patient's condition, which includes the transfer of information regarding the patient's history, overall condition and vital signs.

IFT level 1 or level 2 requests should ordinarily be made by the clinical staff responsible for the patient unless clinical factors require the call to be made by non-clinical staff. However, where calls are made by non-clinical staff on behalf of the clinician, these should be handled in exactly the same way.

### 3.1 Question order for IFT bookings

#### **Call answer**

Where the caller identifies themselves as requiring an IFT response (in line with the above definition) either via 999 or a dedicated IFT line, call takers must ask Q1 as set out below. It is acknowledged depending on different CAD/triage systems, that trusts may need to ask other questions prior to entering the framework such as address verification.

<<<< Entry point into IFT Framework >>>>

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Q1

**Do you need our clinical help right now to deliver an immediate life-saving intervention or are you declaring an obstetric emergency?**

**If YES – Process through trust 999 triage procedure (AMPDS, NHS Pathways), including use of pre-triage sieve and nature of call.**

- Where the call codes as an IFT Level 1 (Category 1) response in triage resources to be allocated as appropriate.
- Where the call codes as an IFT Level 2 (Category 2) response in triage resources to be allocated as appropriate (see note below if declared obstetric emergency).
- Should the call code lower than an IFT Level 2 (Category 2) response, trusts should ensure local policy and procedures exist to immediately flag the call, upgrading if appropriate.
- All declared obstetric emergencies not coding as an IFT Level 1 (Category 1) response should be upgraded to an IFT Level 1 (Category 1) response.

**If NO – Go to Q2.**

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Q2

**Is there a need for an immediate intervention that cannot be carried out at the current facility and is the patient at immediate risk of death or life-changing loss of a limb or sight?**

- For example: transfer directly to theatre for immediate neurosurgery or PPCI, **mechanical thrombectomy for stroke or** thrombectomy for a critically ischaemic limb.

**If YES = IFT Level 2 (Category 2) Response** – closest emergency ambulance to be despatched immediately.

**If NO – Go to Q3.**

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Q3

### **Does the patient require additional clinical management upon arrival at the new facility?**

This may include emergency diagnostics or emergency surgery which is taking place within a set time period (to be defined by local commissioning) of less than 24 hours, ie 4 hours.

For example: Patient with sepsis going to a high dependency unit, patient being transferred to a burns centre, referral for inpatient services not provided at current facility – eg cardiology, surgical speciality, ENT emergencies with no evidence of hypovolaemia, step up in care to specialist unit – coronary care, high dependency units or specialist nursing care and patient in mental health crisis sectioned under the Mental Health Act and requiring admission to a specialist mental health facility.

**If YES = response in line with locally commissioned IFT service of IFT Level 3.**

**If NO = IFT Level 4.**

This level of IFT response may also be used for issues with bed availability of critical or specialist care capability. Patients being transferred to a normal ward environment do not fall into this category.

## **3.2 Time critical transfers**

Patients who require immediate life-saving intervention as a result of assessment/diagnosis within a healthcare facility should have an ambulance immediately dispatched to that facility. If an ambulance is not immediately available for dispatch this incident should be escalated within the ambulance operations centre to ensure an appropriate response.

Ambulance trusts should have appropriate clinical support and decision making processes in place for transfers requiring escalation or where there are additional factors that need to be considered in order for the patient to be matched to the correct clinical priority definitions.

Clinical discretion should be applied in some cases where the patient's condition does not precisely meet the definition but additional considerations are involved, such as with end of life care.

## 4. Reporting

Ambulance trusts should be able to report IFT Level 1 to 4 requests separately from core 999 emergency activity. Please refer to the Ambulance System Indicators guidance: <https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/>

NHS commissioners and ambulance trusts should jointly audit compliance with this framework.

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