CLINICAL PLANNING | GUIDANCE ARTICLE | SEPTEMBER 2026

# When Does a Patient Transfer Require Paramedic-Level Clinical Support?

*The vehicle moves the patient. The clinical plan must carry their care.*

By Claudia Elizabeth Goward, BSc (Hons), HCPC-registered paramedic

**Claudia Elizabeth Goward, BSc (Hons) Paramedic Science, HCPC-registered paramedic**
**Co-founder, Compass Prehospital**

**PLANNING QUESTION When does a patient transfer require paramedic-level clinical support?**

## EXECUTIVE BRIEF

A stable patient with predictable needs may be transferred safely by a competent non-paramedic crew. Others need more. During a journey, access to diagnostics, extra staff and emergency equipment narrows just as assessment, treatment or escalation may become necessary.

Paramedic-level support is justified by foreseeable need, not mileage, diagnosis or destination alone. Consider the patient's trajectory, dependencies, journey and the real capability of the proposed crew.

Not every transfer needs a paramedic, and a paramedic cannot replace a critical care team or specialist escort. Match the crew, equipment, medicines and escalation plan to the highest credible need during the journey.

## 01 | Begin with need, not the vehicle

The transfer starts before the trolley moves and ends when the receiving team accepts responsibility. A patient who looks stable in a bed space may become higher risk once monitoring is disconnected and movement begins.

National guidance takes a risk-based approach. The patient's condition, dependencies and deterioration risk should determine escort competence, alongside the journey and likely interventions. [1,2,3]

**IMPORTANT DISTINCTION Transport eligibility asks how the patient can physically reach the destination. Clinical transfer planning asks what care may be required before, during and immediately after that journey, and who can safely provide it.**

## 02 | Stability is more than one set of observations

One reassuring observation set does not prove low risk. The numbers may look better because oxygen, analgesia, fluids, positioning or recent treatment is working. Ask whether that improvement will hold through movement, delay and reduced support.

Review the trend, treatment response and relevant investigations. Consider co-morbidity and the consequence of deterioration. NEWS2 informs the picture; it does not replace clinical judgement. Age or diagnosis alone should not trigger paramedic provision when needs are genuinely stable and predictable. [4]

**CLINICAL TEST Would the proposed crew recognise meaningful deterioration early enough, understand its likely significance and be authorised and equipped to act before help could realistically arrive?**

## 03 | Five factors that raise the required capability

Paramedic-level support becomes more relevant when one or more of the following factors create a need for autonomous registered clinical judgement or treatment during transfer:

- Current physiological concern: abnormal or changing airway, breathing, circulation, neurological status, temperature, pain or other observations that require interpretation and reassessment.
- A credible risk of deterioration: recent instability, incomplete response to treatment, time-sensitive pathology, significant co-morbidity or a condition in which change may be rapid or difficult to detect.
- Clinical dependencies: oxygen titration, cardiac monitoring, vascular access, medicines, devices, wounds, drains or other treatment that may require active management rather than passive carriage.
- A meaningful intervention may be required: airway support, ventilation, defibrillation, treatment of an acute arrhythmia, seizure, hypoglycaemia, bronchospasm, anaphylaxis, haemorrhage, severe pain or another foreseeable emergency within the clinician's authorised scope.
- The transfer creates exposure: a long journey, remote route, difficult access, prolonged loading, uncertain delays, cross-border repatriation or a destination where immediate clinical reception cannot be assumed.

Risk is cumulative. Stable oxygen at an unchanged flow may not require a paramedic. Recent desaturation, rising oxygen need, limited reserve or a long journey may push foreseeable need beyond the crew's verified capability.

## 04 | The journey changes the risk

Loading, unloading and handover can be the highest-risk phases: the patient moves, devices are handled and monitoring may pause. Noise, vibration, traffic and restricted access also make assessment and treatment harder.

Long journeys add clinical and logistical demands. Oxygen, power and medicines must cover delays. Pressure care, comfort and diversion planning also need attention. The longer the patient is away from fixed clinical support, the less safe it is to plan only for an uncomplicated journey.

**PLANNING OUTCOME Assess risk across the complete transfer timeline: preparation, movement to the vehicle, loading, travel, foreseeable delay, unloading and acceptance by the receiving team.**

## 05 | What paramedic-level support adds

A registered paramedic adds autonomous assessment and repeated clinical decision-making. Rather than recording observations alone, the paramedic can interpret trends in the context of the patient's diagnosis, treatment response, co-morbidity and journey. [6]

Within individual scope and the provider's governance, the paramedic may adjust agreed treatment, administer authorised medicines, manage foreseeable emergencies and decide when the original plan is no longer safe. This includes seeking clinical support, requesting additional resources, diverting or escalating to emergency services. [5,6,8]

Paramedic support also strengthens continuity. One clinician can review the referral information, establish a baseline before movement, reassess through loading and travel, document change and give a structured handover. The benefit depends on suitable equipment, medicines authority, current competence and access to clinical advice; registration alone does not supply those systems. [1,5,6,9]

## 06 | A paramedic is not automatically the right answer

Registration does not make every paramedic suitable for every transfer. Ventilated patients, complex infusions and higher-risk critical care usually require enhanced training and a specialist transfer system. A standard ambulance crew should not be used as a substitute for a second critical care escort.

Some neonatal, paediatric, obstetric, bariatric, mental health and spinal transfers may also exceed general paramedic scope. If a hospital team travels, responsibilities must be explicit. More people do not fix a competence gap. [2,3]

**PROFESSIONAL BOUNDARY Commission the competence required, not the job title alone. Before accepting the transfer, confirm training, recent experience and scope. Medicines authority, equipment familiarity, indemnity and clinical support must also be clear.**

## 07 | Preparation should reduce preventable deterioration

Correct what is safer to correct before departure, without delaying definitive care. Confirm identity and consent or capacity arrangements. Review recent trends and treatment response. Check devices, oxygen, monitoring targets and time-critical medicines. Confirm the ceiling of care, records and destination acceptance.

Equipment must fit the patient and vehicle, remain secured and be usable while staff are restrained. Oxygen, power, medicines and consumables must cover delay as well as planned travel.

Name the diversion options. 'Call for help if they deteriorate' is not a transfer plan.

## 08 | Medicines carried during transfer

Part 3 of Schedule 17 to the Human Medicines Regulations 2012 allows paramedics to administer specified medicines for immediate, necessary treatment. Schedule 19 provides a separate emergency exemption for listed prescription-only medicines used to save life. Neither creates a universal paramedic drug bag.

Before departure, confirm which medicines are actually carried under the provider's governance. Define the formulary and supply route. Storage, controlled-drug arrangements, checks and documentation must be clear. The paramedic must be competent, authorised and within scope.

Foreseeable emergencies may justify access to relevant medicines. Patient-specific drugs, infusions and specialist therapies may need a prescription or another formal authority, such as a PSD or PGD. Some require a hospital escort. Legal availability alone does not make carriage appropriate. [8]

**MEDICINES PRINCIPLE Confirm what is carried, why it is required, who may administer it and under which governance route before the patient leaves the referring setting.**

## 09 | Handover is a transfer of responsibility

Handover should explain why the patient was transferred and describe their baseline, trend and treatment. Include allergies, relevant risks, devices and outstanding investigations. State the ceiling of care and describe any events in transit.

Arrival is not acceptance. The escort retains care until an appropriate receiving professional has accepted the patient and information. Record any deterioration, treatment, delay, diversion or incident.

## 10 | Commission the capability the patient may need

There is a legitimate range of transfer capability. A stable patient who needs safe conveyance, comfort, mobility support and routine observations may be appropriately supported by an ambulance care assistant or another competent patient-transport crew. The provider must still match staffing, vehicle and equipment to the assessed need. [7,9]

FREC 4 is a valuable pre-hospital qualification. It may be proportionate when the patient's condition and needs are stable and predictable, and the commissioned role sits within the crew's verified competence, equipment and escalation arrangements. FREC 4 is not HCPC paramedic registration and does not confer autonomous paramedic practice. Where clinical uncertainty, deterioration, medicines or a change of plan is credible, registered paramedic support may be proportionate. [6,7,9]

At the other end of the range, critical illness, ventilation, complex infusions or specialist dependencies may require an adult critical care transfer service, retrieval team or hospital specialist escort rather than a general paramedic crew. [2,3]

Published inspections do not establish that a particular qualification caused an incident. They do show the wider risk of mismatching assessment, preparation, staff competence and equipment to patient need:

- A CQC inspection of an independent ambulance provider found no documented needs assessment for an inter-hospital cardiac transfer, creating a risk that the crew would not know the patient's needs or provide appropriate care. [10]
- The same inspection found transfers cancelled when crews arrived because booking information did not match patient need. It also found missing evidence of staff competence for equipment including defibrillators and oxygen. [10]

The lesson is to match the escort to the highest credible need. For some patients that is routine ambulance transport with a competent ambulance care assistant. Others may be suitably

supported by a FREC 4 crew working within a defined scope. Patients who may need autonomous reassessment, medicines or a material change to the plan may require a registered paramedic. Critical care and specialist dependencies require the corresponding specialist transfer team or escort.

Commissioning principle: do not plan only for an uncomplicated journey. Confirm that the accompanying team can recognise and manage foreseeable deterioration, with specialist support where required.

### EIGHT QUESTIONS BEFORE DEPARTURE

- What is the reason for transfer, and how time-critical is definitive care?
- Is the patient stable over time, or stable only because current treatment is working?
- What deterioration is credible, how quickly could it occur and how would it be recognised?
- Which monitoring, medicines, devices or interventions must continue during every phase?
- Does the proposed crew have the verified competence and authority to manage those needs?
- Do the vehicle, equipment, oxygen, power and consumables cover the journey plus delay?
- Where will the team divert or seek support if the plan changes?
- Have acceptance, documentation, treatment limits and handover responsibility been confirmed?

## 11 | What Compass Prehospital can provide

Compass Prehospital can provide HCPC-registered paramedic capability for planned higher-acuity, long-distance and repatriation transfers, informed by four years of operational experience in patient transport. Work is delivered within the governance of an appropriately registered transport or healthcare provider. Each request is assessed against the patient's condition and dependencies, the journey, the equipment required and the clinician competence needed.

Support may begin with a pre-transfer information review and collection assessment. During the journey it can include agreed monitoring, treatment within authorised scope, reassessment and documented escalation. Compass also provides structured handover. Compass does not independently commission or operate an ambulance transport service. Its paramedic provision does not replace a critical care transfer service, specialist retrieval team or hospital escort where one is indicated.

### ABOUT THE AUTHOR

Claudia Elizabeth Goward is a First Class BSc (Hons)-qualified, HCPC-registered paramedic and co-founder of Compass Prehospital. Her background includes frontline ambulance care, urgent and emergency care, and four years of patient-transport experience. This briefing reflects a general paramedic and transfer-planning perspective, not specialist retrieval accreditation.

### EVIDENCE AND GUIDANCE

1. NHS England. National framework for inter-facility transfers. Version 3, updated 12 December 2024.

2. Intensive Care Society and Faculty of Intensive Care Medicine. Guidance on the Transfer of the Critically Ill Adult. Fifth edition, 2026.

3. NHS England. Adult Critical Care Transfer services. Updated 5 November 2024.

4. Royal College of Physicians. National Early Warning Score (NEWS2).

5. Resuscitation Council UK. Quality Standards: Acute Care – Patient Transfer.

6. Health and Care Professions Council. Standards of proficiency: Paramedics.

7. Care Quality Commission. Service inspections: independent ambulance services. Updated 9 May 2025.

8. Human Medicines Regulations 2012, including Part 3 of Schedule 17 and Schedule 19.

9. Care Quality Commission. Monitoring questions for ambulance services: patient transport services.

10. Care Quality Commission. Criticare UK Ambulance Service: all inspections; report published 11 April 2018.

This briefing is general educational and planning guidance. It should be read alongside the individual patient's assessment, the commissioning provider's clinical governance and policies, local or regional transfer pathways, vehicle and equipment requirements, and current specialist guidance. Review annually or following material regulatory, clinical or operational change.

Compass Prehospital Limited | Registered in England and Wales | Company No. 17337979 | compassprehospital.co.uk