



Framework to support inter-hospital transfer of critical care patients

9 December 2021, Version 1

Background

1. This framework provides an update on the previous patient selection guidance included in the NCCTC Transfer Request Form v3 from Wave 2 of the COVID-19 pandemic.
2. Maintenance of emergency and urgent elective capacity and pathway management is key to the delivery of equitable services for all patients.
3. This document sets out principles to which units and systems should adhere, to maintain equitable and safe access to critical care for both **emergency** and **urgent** planned care patients.

Role of the providers, integrated care systems (ICS) and regions

4. Providers, systems and regions must make all reasonable efforts to minimise the need for transfers for non-clinical reasons.
5. Interventions and structures should be in place or in development to avoid unnecessary transfer, for example:
 - Concentration of urgent elective surgical services on 'cold' sites within a trust or system.
 - Assurance that all delayed discharges have been resolved and discharge completed, and that beds are available for critical care admissions.
 - Development of enhanced perioperative care services which prioritise urgent elective interventions.
6. Regions and systems should develop or have access to a dedicated and fully resourced 7-day per week adult critical care transfer service (ACCTS) to ensure any transfers required are conducted to the highest possible standard.

Indications for transfer

7. Critical care patients should only be transferred between hospitals for one of the following reasons:
 - their own clinical care requires expertise unavailable in their current critical care unit or hospital ('clinical transfers')
 - the treating critical care unit is under extreme clinical pressure and the patient is likely to benefit from moving to a less busy unit ('mutual aid/surge transfers')
 - the patient is being repatriated closer to home, family, friends or carers ('repatriation')
 - the treating critical care unit needs to create capacity to facilitate emergency or urgent clinical care for other patients ('capacity transfers').

This document sets out the principles underpinning clinical and operational decision-making for the last of these reasons: capacity transfers.

Circumstances necessitating a critical care capacity transfer

8. Transfer of a patient occupying a critical care bed for any reason other than to benefit their own clinical care (ie a capacity transfer) is only to be undertaken when all other reasonable options have been exhausted.
9. Transfer may be undertaken to create critical care capacity for:
 - a patient requiring emergency critical care interventions
 - a patient requiring P1 (emergency, requires treatment within 72hr) surgery/intervention and perioperative critical care
 - a patient requiring P2 (urgent, requires treatment within 1 month) surgery/intervention and perioperative critical care, whose individual risk of serious morbidity or reduced survival would be significantly increased if surgery was to be delayed. This risk must be determined by the treating surgical/interventional consultant and agreed by at least one other suitably qualified consultant. Examples would include patients requiring urgent cancer, cardiac, neurological or vascular surgery.

Patient selection for safe critical care transfer

10. Any decision to undertake a capacity transfer must be made:
 - by a critical care consultant
 - in consultation with at least one other critical care consultant
 - in consultation with the nurse in charge of the unit

- if applicable, with the agreement of the medical/surgical consultant responsible for that patient's care
 - with the agreement of the trust executive team
 - with the agreement of the patient (if they have capacity for decision-making), and/or the patient's next of kin or an independent mental capacity act practitioner in the absence of next of kin.
11. No patient should be transferred for capacity reasons if safe transfer would require a significant or potentially deleterious change in treatment. An example of when **not** to select a patient for transfer might be a patient who is close to being extubated and lightly sedated, who would require re-sedation and ventilation to facilitate a transfer.

Ensuring a safe transfer for patients and their families

12. Capacity transfers should, in most instances, be undertaken during normal working hours. They should use a dedicated critical care transfer service and be delivered by an appropriately trained senior physician and appropriately trained nurse or other health professional, such as an advanced critical care practitioner or operating department practitioner.
13. The standard of supervision and monitoring provided to the patient being transferred should be higher than that they were receiving prior to moving from their critical care unit (ie one-to-one medical support as well as nursing support).

See transfer specification and Surge Plan for further guidance:

- <https://www.england.nhs.uk/publication/adult-critical-care-transfer-services/>
 - <https://www.england.nhs.uk/commissioning/publication/management-of-surge-and-escalation-in-critical-care-services-standard-operating-procedure-for-adult-critical-care-transfer-services/>.
14. A full, transparent explanation of the rationale for the individual patient being approached for transfer and the reason for transfer should be provided to the patient/next-of-kin.
15. Patients should ideally be transferred to a unit as close as possible to their regular visitors (if applicable), provided that this unit is less busy than the treating unit.
16. Agreement should be reached between units with the agreement of the patient/their next of kin regarding timely repatriation, particularly at the time of step-down to ward level care.

Governance and reporting

17. The adult critical care transfer services must:

- collect and report operational and clinical national mandatory minimum data sets and clinical incident summaries for all referrals and transfers as described in contracts; this will include those undertaken by referring hospital clinical teams or other providers
- record all clinical incidents, including them in transfer records and follow host trust and regional processes for investigation, reporting and improvement
- submit adult critical care (ACC) research and audit data to support national analysis of transfer activity and ongoing research into ACC patient outcome that aligns with current audit and is case-adjusted as part of the patient pathway
- produce regular activity reports and an annual report for all stakeholders and service commissioners
- report to the ACCTS Regional Partnership Board, or equivalent.