NHS
Critical Care Network
East Midlands

Admission, Operational and Discharge and Transfer Policy

April 2024

".....Your Patient is My Patient..."

Critical Care Network
East Midlands

Classification: General

Organisation	East Midlands Critical Care Network
Document Purpose	Guidance
Title	East Midlands Critical Care Admission, Operational and Discharge and Transfer Policy
Author	Network Clinical Steering Group
Date and Version	April 2024 v3.2
Linkages	Department of Health - Comprehensive Critical Care Intensive Care Society Transfer Guidelines Network Transfer Audit Reports
Circulation (via Network Board and Clinical Groups)	Network Clinical Leads Provider/Acute Trusts and Commissioner organisations and East Midlands Ambulance Service NHS Trust via Network Groups
Description	This document outlines the admission, operational and discharge and transfer policy for adult Critical Care services in the East Midlands Critical Care Network. It is to be noted that this Policy is circulated as guidance for adult critical care services only
Point of Contact	Dr Adam Wolverson, Network Medical Lead Craig Esberger, Senior Network Manager
Contact Details	East Midlands Critical Care Network East Midlands Ambulance Service NHS Trust Beechdale Road Nottingham NG8 3LL adam.wolverson@ulh.nhs.uk craig.esberger@emas.nhs.uk
Review date	March 2026 (or sooner if ongoing review is required)

Version Control

Version	Date	Name	Changes
3.1	April 2022	Craig Esberger	Updated to most recent Network position and document format
3.2	April 2024	Craig Esberger	Addition of a section for Leicester General patients. Updated Scope Updated Appendix G Updated guidance and links

Contents

1. Introduction 5
2. Scope 7
3. Admission Policy 7
4. Emergency admissions 8
5. Planned elective critical care admissions 9
6. Planned elective admissions from operating theatres when there are no available critical care beds 10
7. Admissions for end of life care 10
8. Provision of critical care support outside of designated critical care areas 10
9. Critical Care Unit admission status 11
10. Transfer of patients 11
11. Level 2 transfers 11
12. Transfer of patients with infection control risks 12
13. Referrals to critical care from outside the hospital 12
14. Referral to a non-critical care specialist Consultant for lifesaving intervention 12
15. Referral to a non-Critical Care Consultant for elective or urgent, but non-life-saving intervention 13
16. Referrals direct to critical care of patients requiring on-going critical care 13
17. Refused external admissions 14
18. NHS Sites without on-site critical care facilities 14
19. Operational and Discharge Policy 16
20. Intensive Care Clinical Governance 20
21. Notification of General Practitioners 21
22. Organ Donation 21
23. Major Incident/Mass Casualty/Pandemic 22
24. Network Bed State 22
25. Bed Closures Baseline 22
26. Independent Providers 22
27. Quotient Sciences 24
28. Complaints 24
29. Interdependence with Other Services 24
30. Transfer Policy 26

Appendix A - Pathway for the referral of patients requiring lifesaving surgery/intervention at NUH 30
Appendix B – Framework to Support Inter-Hospital Transfer of Critical Care Patients (B1215) 31
Appendix C - Principles for ACC Mutual Aid via ACCOTS 31
Appendix D – Referral to ACCOTS 31
Appendix E - Information for Relatives Regarding Transfer 31
Appendix G - Network Wide EMAS Ambulance Transport Booking Procedure 32
Appendix G1 - Ambulance Booking Procedure 40
Appendix H - Legislation Regarding High Visibility Clothing 41

1. Introduction

1.1. This policy document sets out the detailed admission and operating procedure for adult critical care services in the East Midlands Critical Care Network (the Network). This includes Level 3 (Adult Intensive Care Unit - AICU) and Level 2 (High Dependency Unit - HDU) beds, critical care outreach services and flexible, extended provision of critical care outside of discrete critical care units where these exist. It also sets out the Transfer and Discharge Policy for the transfer and discharge of critically ill patients between and from critical care units in the Network.

1.2. The overall aim of the Network is to ensure equity of access, care and timely admission to and discharge from adult critical care for all appropriate patients and to ensure critical care services are delivered in line with the National Service Specification for Adult Critical Care Services 170118S (Previously D05/D16)[1]. Minimum standards for critical care are consistent across all services regardless of case mix or commissioning body (NHS England specialised commissioning or Local Clinical Commissioning Group commissioning).

1.3. In addition to the minimum requirements of the national service specification, critical care services should be delivered in keeping with the latest national guidance provided by the joint Faculty of Intensive Care Medicine (FICM)/Intensive Care Society |(ICS) Guidelines for The Provision of Intensive Care Services (GPICS)[2] and critical care transfers should be undertaken in keeping with the latest ICS Guidance on the Transfer of the Critically Ill Adult.[3]

1.4. In the interest of clarity, the language used is stark, however the underlying philosophy of the critical care areas is of shared care between referring and receiving Critical Care Consultants. Referring Consultants will be expected to take an active role in the management of patients referred to critical care services. The joint management of patients by the referring Consultant and the receiving critical care Consultant team will ensure that the patient benefits from the expertise of both.

1.5. At Trust level, the Executive Director with specific responsibility for critical care will oversee implementation of this Policy and will investigate adverse incidents at a Trust level as per local protocol.

1.6. Critically ill patients are classified by three levels of care as follows[4];

---

[1] NHS England, 2019. Adult Critical Care Service Specification (170118S). Available: https://www.england.nhs.uk/publication/adult-critical-care-services/

[2] The Faculty of Intensive Care Medicine, Intensive Care Society, July 2022. Guidelines for the Provision of Intensive Care Services Edition 2.1. Available from: https://www.ficm.ac.uk/sites/ficm/files/documents/2022-07/GPICS%20V2.1%20%282%29.pdf

[3] The Faculty of Intensive Care Medicine, Intensive Care Society, May 2019. Guidance On: The Transfer of the Critically Ill Adult. London

[4] Intensive Care Society, March 2021. Levels of Adult Critical Care Second Edition. Available from: https://www.ics.ac.uk/Society/Patients_and_Relatives/Levels_of_Care

Ward Care

- Patients whose needs can be met through normal ward care in an acute hospital.
- Patients who have recently been relocated from a higher level of care, but their needs can be met on an acute ward with additional advice and support from the critical care outreach team.
- Patients who can be managed on a ward but remain at risk of clinical deterioration.

Level 1 – Enhanced Care

- Patients requiring more detailed observations or interventions, including basic support for a single organ system and those 'stepping down' from higher levels of care.
- Patients requiring interventions to prevent further deterioration or rehabilitation needs which cannot be met on a normal ward.
- Patients who require on going interventions (other than routine follow up) from critical care outreach teams to intervene in deterioration or to support escalation of care.
- Patients needing a greater degree of observation and monitoring that cannot be safely provided on a ward, judged on the basis of clinical circumstances and ward resources.
- Patients who would benefit from Enhanced Perioperative Care.[3]

Level 2 – Critical Care

- Patients requiring increased levels of observations or interventions (beyond level 1) including basic support for two or more organ systems and those 'stepping down' from higher levels of care.
- Patients requiring interventions to prevent further deterioration or rehabilitation needs, beyond that of level 1.
- Patients needing two or more basic organ system monitoring and support.
- Patients needing one organ systems monitored and supported at an advanced level (other than advanced respiratory support).
- Patients needing long term advanced respiratory support.
- Patients who require Level 1 care for organ support but who require enhanced nursing for other reasons, in particular maintaining their safety if severely agitated.
- Patients needing extended post-operative care, outside that which can be provided in enhanced care units: extended postoperative observation is required either because of the nature of the procedure and/or the patient's condition and co-morbidities.
- Patients with major uncorrected physiological abnormalities, whose care needs cannot be met elsewhere.
- Patients requiring nursing and therapies input more frequently than available in level 1 areas.

Level 3 – Critical Care

- Patients needing advanced respiratory monitoring and support alone.
- Patients requiring monitoring and support for two or more organ systems at an advanced level.
- Patients with chronic impairment of one or more organ systems sufficient to restrict daily activities (co-morbidity) and who require support for an acute reversible failure of another organ system.
- Patients who experience delirium and agitation in addition to requiring level 2 care.
- Complex patients requiring support for multiple organ failures, this may not necessarily include advanced respiratory support.

2. Scope

2.1. This Policy relates to all critical care facilities in the Network as follows:

2.1.1. Chesterfield Royal Hospital Foundation Trust
2.1.2. Kettering General Hospital NHS
2.1.3. University Hospitals of Leicester NHS Trust
- Glenfield Hospital
- Royal Infirmary Hospital
- Leicester General Hospital

2.1.4. Northampton General Hospital NHS Trust
2.1.5. Nottingham University Hospitals NHS Trust
- Queen's Medical Centre
- City Hospital
- Nottingham Treatment Centre

2.1.6. University Hospitals of Derby and Burton NHS Foundation Trust
- Royal Derby Hospital
- Queen's Hospital Burton

2.1.7. Sherwood Forest Hospitals NHS Foundation Trust
- King's Mill Hospital

2.1.8. United Lincolnshire Hospitals NHS Trust
- Lincoln County Hospital
- Boston Pilgrim Hospital
- Grantham Hospital, ACU

2.1.9. BMI Healthcare, The Park Hospital, Nottingham
2.1.10. Spire Healthcare, Spire Nottingham Hospital
2.1.11. Other Private Providers with planned in-patient surgical facilities in the region

3. Admission Policy

3.1. Patients are admitted to critical care areas for life supporting treatment or for monitoring, investigation and care which is only available in such Units. Admission to critical care beds or ward based acute care supported by critical care outreach team (CCOT) services may also be required to prevent anticipated deterioration in patients to the extent that they require invasive therapy.

3.2. Patients should have a reasonable prospect of final cure or of a recovery, which would be better than could be achieved without admission. Patients should not be admitted to critical care against their previously stated and appropriately documented wishes as per the Mental Capacity Act.[5]

N.B Patients in groups for which there is evidence that critical care does not offer benefit should only be admitted in exceptional circumstances. As per section 7 below however, admission for prognostication/end of life care may be considered appropriate.

3.3. The decision to admit a patient to critical care must be made by a Consultant in Intensive Care Medicine (as defined by the Faculty of Intensive Care Medicine). All potential patients for ICU admission should be discussed with the Critical Care Consultant of the day/on call. Any Consultant may refer patients to critical care services and referrals should be made Consultant to Consultant. Non-Consultant ICU medical staff should not accept or refuse patient admission without discussion with the on-call ICU Consultant. On admission to Critical Care, all patients must have a treatment plan discussed with a Consultant in Intensive Care

[5] Mental Capacity Act 2005. Available from: https://www.legislation.gov.uk/ukpga/2005/9/contents

Medicine and the patient must be seen and reviewed within 12 hours by a Critical Care Consultant.[6]

3.4. If there is a major disagreement between the referring Consultant and the ICU Consultant on call regarding admission of a patient to critical care, the advice of another Critical Care Consultant can be sought, and their advice should be accepted. Ultimately however the decision to admit a patient to the critical care unit remains a Critical Care Consultant decision.

N.B. ONLY in exceptional circumstances, such as an immediate life-threatening emergency, critical care admission may be organised between critical care medical staff and the medical staff of the referring team at non-Consultant level. It is then the responsibility of each to inform their Consultant of the situation as soon as is practicable.

3.5. The criteria for acceptance to critical care services is based on clinical need and the urgency of that need. Clinical guidelines for admission and discharge are summarised in the Department of Health document "Guidelines on admission to and discharge from Intensive Care and High Dependency Units".[7] Patients may require critical care support at ward based, level 1 admission to a local enhanced care area, admission for level 2 or level 3 care to a local critical care unit or in exceptional circumstances, or for tertiary level care not available locally, transfer to another critical care resource within the East Midlands Network. These are to be co-ordinated through the ACCOTS service by the referring unit.

3.6. If transfers are required outside of the Network then national agreement needs to be sought by the referring unit.

4. Emergency admissions

4.1. All Trusts should implement a standardised approach to the detection and response to deteriorating health on general wards with reference to NICE Clinical Guideline 50[8] to identify patients who may require critical care support.

4.2. Emergency/unscheduled patients should be admitted to the critical care unit (or where appropriate, a recognised critical care surge facility) within four hours of the decision to admit in line with the 170118S Service Specification.[6] Where delays in admission extend beyond four hours, this data will be reported as a clinical incident within the Trust, with delayed admissions data reported monthly to the Network in line with the Network Benchmarking measures. To support monitoring of these indicators, a time of referral review and arrival ICU should be recorded on the transfer forms and where appropriate logged on the relevant Trust's Patient Administration System.

4.3. When a critically ill patient is referred directly to critical care from the Emergency Department (and not to any other specialty), the on-call team from the appropriate specialty will be informed and will review the patient in critical care as soon as possible and within no more than 12 hours of the patient's admission to facilitate shared care and expedite eventual discharge. *Critical Care Teams reserve the right to seek the opinion of any specialist in the best interest of the patient.*

4.4. The nurse-in-charge will be consulted with, prior to accepting a referral, to ensure that adequate numbers of nursing staff are available to care for a new admission.

---

[6] NHS England, 2019. Adult Critical Care Service Specification (170118S). Available: https://www.england.nhs.uk/publication/adult-critical-care-services/

[7] Department of Health, March 1996. Guidelines on admission to and discharge from Intensive Care and High Dependency Units. London

[8] NICE, 2007. Clinical guideline [CG50]. Acutely ill adults in hospital: recognizing and responding to deterioration https://www.nice.org.uk/guidance/cg50

4.5. In the absence of available critical care resources, the Critical Care Unit Surge Plan will indicate where patients should be managed. Activation of Critical Care Surge Plans should be notified to the Network and recorded in the Trust incident reporting system as appropriate. Bed availability and the implementation of surge should be appropriately recorded on the NHS Directory of Services (DoS)[9] to facilitate bed management across the Network.

4.6. If inadequate resources are available, while the transfer of a level 3 patient for comparable critical care at another acute hospital (non-clinical transfer) should be avoided if at all possible, resources elsewhere in the Network may have to be utilised to enable safe patient care following discussion with both Consultants caring for the patient and those elsewhere in the Network.

5. Planned elective critical care admissions

5.1. Planned Elective admissions must be booked in advance of the planned date of admission and Trusts should ensure appropriate planning of elective surgical admissions to critical care to avoid unnecessary postponement of surgery. Elective admissions should be recorded in an Admissions Diary/Electronic Critical Care Booking System following locally agreed Trust processes. Bookings will be accepted for specific patients only. Substitution of patients must be negotiated between the Surgical Team and with the Critical Care Team.

5.2. On the day of planned admission, the referring Consultant Anaesthetist responsible for the case and Surgical Consultant's team will liaise directly with the medical and nursing staff on the critical care unit as early as possible.

5.3. Elective surgical patients who are identified at pre-operative assessment in sites with no critical care facility as needing post-operative critical care should be booked as elective critical care admissions and transferred to an appropriate facility for surgery in line with local Trust policy.

5.4. When no critical care beds are available, a patient may be deferred or cancelled; local Trust Policy for the deferment/cancellation of elective cases should be followed in such cases. A deferred patient is one whose clinical condition is such that they need to remain in the hospital to await the next appropriate operating slot and must take precedence over other planned/booked cases, which require critical care. A cancelled patient is a patient that has been discharged and given a new admission date.

5.5. When a patient is deferred or cancelled by critical care as a result of emergency pressures, the patient should be re-booked as soon as possible, and a note made of the deferment/cancellation. Preference will then be given to such patients over "advance bookings" in order to avoid second cancellations wherever possible. If a second cancellation seems likely, the on-call Executive Director with responsibility for critical care within the Trust will be informed and will be responsible for ensuring appropriate action to avoid a second cancellation. Further to the Network Admission and Operational Policy, each Trust will agree a process to avoid second cancellations.

5.6. In each Trust there will be a designated person with operational responsibility for managing elective cancellations effectively, who will report to the Trust Emergency Planning Lead/named Executive Director with responsibility for emergency pressures.

[9] NHS Digital. NHS Pathways Directory of Services (DoS) https://www.directoryofservices.nhs.uk

6. Planned elective admissions from operating theatres when there are no available critical care beds

6.1. An elective case should not be undertaken which may require post-operative critical care if there is no available post-operative critical care resource. It is the responsibility of the Consultant Anaesthetist/duty on-call Consultant responsible for that case, to confirm bed availability before commencing the anaesthetic. If proceeding without an available critical care bed is contemplated, then the surgical team must be made aware and should inform the patient of the possible increased risk. If the operation proceeds in the knowledge that the Trust's critical care resource is operating at capacity, the responsible Consultant Anaesthetist will provide on-going medical care for the patient until a critical care resource becomes available. Critical care skills for the provision of short-term level 3 care is a core skill for all Anaesthetic Consultants.

7. Admissions for end of life care

7.1. It is a UK consensus recommendation that mechanically ventilated patients in the ED with a devastating brain injury should be admitted to ICU for a period of observed prognostication, even when progression to end of life care is the most likely outcome, unless the extent of co-morbidity makes continued organ support of no overall benefit regardless of the extent of potential neurological recovery.[10] The poor prognosis should be explained to the patient's relatives.

7.2. Direct admission of mechanically ventilated patients for the purposes of facilitating end of life care is an acceptable use of critical care resources allowing families greater time to gather and accept their impending loss but must be considered on a case by case basis. In accordance with NICE guidance[11], end of life care must include the early referral of the patient to a Specialist Nurse for Organ Donation and any approach to the family regarding organ donation should be a collaborative approach by a senior critical care doctor and the Specialist Nurse for Organ Donation.

8. Provision of critical care support outside of designated critical care areas

8.1. Where a patient is receiving level 3 care outside the designated critical care area as part of the local surge plan:

8.1.1 It may be appropriate to consider exchanging this patient with one who has a lower care dependency from critical care.

8.1.2 Ventilation of patients outside designated critical care areas (e.g. theatre recovery) should only be undertaken in exceptional circumstances, such as periods of peak demand, even in those Units where it is a possibility.

8.1.3 The critical care medical team is the first point of contact if medical input is required. If an immediate response is required but critical care is unable to respond immediately, the on-call anaesthetic team should be called.

8.2. Such actions will be monitored under the Network critical care protocol – please see Section 19 of this document (Clinical Governance).

---

[10] Harvey D, Butler J, Groves J et al. Management of perceived devastating brain injury after hospital admission: a consensus statement from stakeholder professional organisations. Br J Anaesth 2018; 120: 138e45

[11] NICE, 2011. Clinical guideline CG135. Organ Donation for Transplantation: Improving Donor Identification and Consent Rates for Deceased Organ Donation https://www.nice.org.uk/guidance/cg135

9. Critical Care Unit admission status

9.1. Critical care areas will operate in one of three states (for further details see specific local policies).

9.1.1. Open to all admissions
The critical care unit is able to accept referrals from within the Trust, elsewhere in the Network or outside the Network on the basis of clinical need.

9.1.2. Closed to external transfers
Closed to external non-clinical transfer. NB. No patient for urgent or life-saving interventions can be refused for capacity reasons[12] (see 10.2). Critical Care Surge Plans will need to be enacted if there is no space in the Unit. Closure to urgent lifesaving clinical transfers can only be in the event of catastrophic infrastructure failure or major incident episodes - this may include CRITCON 4 status.

9.1.3. Closed to Emergency Department, and all other internal and external referrals (e.g. 'take' patients)
This will only be in catastrophic infrastructure failure or major incident. In this circumstance existing ICU patients may need to be transferred out (see Network Transfer Policy).

10. Transfer of patients

10.1. The transfer of a level 3 patient for comparable critical care at another acute hospital (non-clinical transfer) should be avoided if at all possible. When a patient requiring critical care cannot be admitted to a critical care bed due to capacity issues (i.e. the requirement to ventilate a patient outside of the critical care environment for a prolonged period or a patient in the Operating Theatre who will definitely require a critical care bed when the critical care unit is already full), any level 1 dependency patient in a level 2 or 3 bed should be prioritised for urgent discharge to a ward. Alternatively, if safe to do so, a lower dependency level 2 patient may be discharged and cared for elsewhere utilising the hospital's critical care outreach resources.

10.2. If the critical care demand cannot be met within the hospitals existing resources, the Critical Care Consultant on duty or on-call may decide to transfer one of the current patients (usually the most stable patient/one requiring the least support) to a critical care area in another hospital within the Network in order to allow the admission of the new referral. The team who referred the patient, who is to be transferred out, will be consulted about the intended transfer. In case of debate, however, the final decision will rest with the Critical Care Consultants in the referring and receiving Units. If there is no available bed to transfer to, then the Critical Care Unit Surge Plan should be implemented which will include appropriate internal and external (e.g. to NHS England & Improvement) escalations.

10.3. Please see Section 30 and Appendix D for more information on the processes and framework for transfers

11. Level 2 transfers

11.1. Level 2 non-clinical transfers
Level 2 patients will not be transferred for non-clinical reasons except in exceptional circumstances with full risk assessment.

[12] January 2017. Regulation 28: Report to prevent future deaths. (Copy available emccn@emas.nhs.uk)

11.2. Level 2 clinical transfers

Patients requiring transfer from a ward bed to a level 2 bed in a Critical Care Unit or High Dependency Unit at another hospital should be regarded as a level 2 critical care transfer. These patients should be assessed by the Critical Care Team prior to transfer and they should help to stabilise the patient. The Critical Care Consultant should help to facilitate the transfer process and advise ward staff on issues such as transfer priority, ambulance booking procedures (Appendix C and D) and skill-mix required for transferring staff. In addition to informing the receiving critical care team, it is good practice to ensure the specialty team at the receiving hospital are aware and have accepted the transfer.

12. Transfer of patients with infection prevention and control requirements to facilitate safe transfer.

12.1. Patients who have been identified as carrying/infected with multi-resistant organisms or other drug resistant organism or have any other infection prevention and control risks, will only in exceptional circumstances be transferred for non-clinical reasons.

12.2. If patients with a known infection prevention and control risk must be transferred for clinical reasons, it is imperative that the receiving critical care team are made aware and advisable that infection prevention and control advice is sought.

12.3. When transferring an infectious patient, consideration is required to ensure a safe, planned route from the ambulance to the receiving unit.

12.4. Appropriate personal protective equipment should be donned prior to the transfer, removed and changed as indicated. Gloves are not a substitute for hand hygiene and should not be worn instead of cleaning hands. Gloves are not normally indicated when transferring a patient to and from the vehicle.

12.5. All vehicles and equipment must be decontaminated using the appropriate cleaning products for the infectious organism and as per IPC policies.

13. Referrals to critical care from outside the hospital

13.1. No patient requiring life/limb saving or clinically emergent interventions not available at the referring hospital site can be refused by a hospital able to provide that intervention for critical care capacity reasons.[13] Patients with major trauma should, if appropriate, by-pass their local Trauma Unit as per the East Midlands Major Trauma Network (EMMTN) primary triage standard operating procedure.[14]

14. Referral to a non-critical care specialist Consultant for lifesaving intervention

(i.e. neurosurgery, vascular surgery, major trauma or acute coronary interventions) in a patient likely to require critical care post intervention)

14.1. If a patient requires lifesaving intervention (surgical, medical or radiological) that cannot be undertaken in the admitting hospital due to expertise or interventional capacity the responsible Consultant should refer directly to a Consultant in another appropriate Trust

[13] January 2017. Regulation 28: Report to prevent future deaths. (Copy available emccn@emas.nhs.uk)
[14] Current copy available from Major Trauma Centre/Trauma Unit or emmtn@emas.nhs.uk

unless the patient is being transferred under the EMMTN Major Trauma "send and call" policies (Appendix B).

14.2. The receiving Consultant, on agreeing that the intervention is required immediately (in under 6 hours) to save life/limb and that this can be undertaken in the receiving Trust should accept the patient for transfer to the receiving hospital irrespective of the critical care bed state. Once the receiving Consultant has confirmed acceptance of the patient, the Critical Care Consultant in charge of Unit beds should be informed of the transfer, the procedure that is planned and the person who has agreed to undertake the intervention if different to the accepting Consultant. Once the patient is transferred, handover from the transferring team needs to be completed as soon as feasible to the receiving team.

14.3. If a critical care bed is required post procedure and can be made available, this should be allocated to the in-coming patient post procedure. If there is no critical care bed capacity, the Critical Care Consultant in charge of the Unit beds will work with the Consultant who has accepted the transfer to determine the most appropriate way to create capacity. This may include a non-clinical transfer of another patient, repatriation of a patient to their local critical care unit, agreement for the new patient to be transferred to an alternative Specialist Unit post intervention such as another Neurosurgical Unit (as described in national guidance such as the SBNS quality statement[15]) or use of escalation (surge) facilities.

14.4. Non-specialist centres will be expected to accept patients for repatriation for whom intervention is completed in specialist centres within 48 hours of referral to maintain bed availability for urgent specialist referrals[16].

15. Referral to a non-Critical Care Consultant for elective or urgent, but non-life-saving intervention

15.1. If a patient requires transfer to another hospital for non-life-saving intervention that is deemed urgent or 'elective' by the receiving Consultant, the Critical Care Consultant in charge of the Unit beds should be contacted. The Consultant in critical care should liaise with the referring Unit to arrange a suitable transfer time depending on bed availability and planned timing of the intervention. In cases where the intervention could be undertaken in a non-specialist hospital, referral should only be made to a specialist centre if no other Units are able to accommodate the patient.

15.2. If, in time, the requirement for intervention changes to become lifesaving rather than elective or urgent, the arrangements should change to those described in section 14.

16. Referrals direct to critical care of patients requiring on-going critical care

16.1. Patients will be accepted if appropriate, by the responsible Critical Care Consultant. A referral should also be made to the appropriate parent team at the receiving hospital and accepted and this team should be asked to see the patient if there is an on-going problem relating to the original cause of critical care admission (i.e. related to or treated by surgery).

16.2. Bed-availability for outside referrals need to be prioritised against elective admissions from within the hospital in the next 24 hours depending on the urgency of the transfer. Elective admissions should not take precedence over external emergency or urgent referrals (i.e. due to time critical interventions or pressure on beds elsewhere in the Network). Repatriations to a base Unit will need to be accommodated within 48 hours of the referral being made.

---

[15] The Society of British Neurological Surgeons (SBNS) Quality Statement. Standards of care for elective and emergency neurosurgery. https://www.sbns.org.uk/index.php/download_file/view/975/87/

[16] NHS England, 2019. Adult Critical Care Service Specification (170118S). Available: https://www.england.nhs.uk/publication/adult-critical-care-services/

16.3. In respect of referrals from overseas; the individual Network Units will attempt to accommodate referrals for overseas repatriation. In the event of a Unit being full however, or unable to isolate an overseas patient appropriately, the Network will look to accommodate the patient in one of its member Units as per the ICS Memorandum of Understanding for overseas critical care repatriations[17]. Once a patient has been accepted for transfer (patient in transit) into a bed from overseas, the unit should ring fence that bed and the patient MUST be accepted regardless of other emergent changes.

17. Refused external admissions

17.1. Transfer for life/limb saving intervention should not be refused on the basis of critical care capacity. Patients being transferred for urgent (not immediate but within 24 hours) intervention should only be refused if the responsible Critical Care Consultant cannot make a bed available in the required time-frame or if the Trust cannot deliver the required procedure within that period. In such cases the referring hospital will need to approach another specialist centre to provide that care. If repatriation to a base Unit is refused beyond the expected 48-hour time period, this should be escalated through both Trust Silver and Gold commands.

17.2. Non-clinical transfers for capacity may be refused by the responsible Critical Care Consultant depending on the critical care capacity and demands on the receiving hospitals bed stock.

17.3. All Units should collect audit data in relation to refused external admissions.

18. NHS Sites without on-site critical care facilities

18.1. Within the Network region, it is recognised that there are a number of sites where acute provider trusts deliver both inpatient and day case care where there is no on-site critical care facility and in some cases no on-site acute medical care. Patients on these sites may on occasion require transfer for on-going critical care.

18.2. Grantham Patients

Grantham District General Hospital (GDGH) is unique within the Network in providing acute medical services and elective in-patient surgical care with no on site critical care beds. The site does have a level 1 Acute Care Unit (ACU) both for medical and elective surgical cases. The ACU operates a stabilise and transfer policy for all patients on the site who require level 2 or level 3 critical care support. Once a patient is identified as potentially requiring critical care then the GDGH Consultant responsible for the patient should discuss the patient with the United Lincolnshire Hospitals NHS Trust (ULHT) Critical Care Consultant on-call via switchboard. This contact is for clinical advice only. This Consultant to Consultant referral should include a discussion about the presentation of the patient, and accurate past medical history and co-morbidity status.

18.3. Once the patient has been discussed by the referring and ICU Consultants if it is deemed clinically appropriate to transfer the patient, the ULHT Critical Care Consultant will identify the availability of critical care beds within the ULHT Critical Care Units. If an ICU bed is available, the patient should be referred to ACCOTS (see section 30) to facilitate the transfer. Exception to this is where the patient's needs cannot be met within ULHT (i.e. neuro, cardiac, thoracic input or major trauma care) and the patient will need to be transferred to the most appropriate centre for on-going care or if the transfer is not for a time critical intervention but no ULHT ICU bed is available, in which case an appropriate critical care bed within GDGH

[17] Intensive Care Society. Guidance for the repatriation of critically ill patients from international hospitals to UK critical care Units. Available from: https://www.cc3n.org.uk/uploads/9/8/4/2/98425184/guidance_for_the_repatriation_of_critically_ill_pa.pdf

unique transfer group should be identified via the ACCOTS co-ordinator. Where ACCOTS are unable to provide clinical assistance, transfer of GDGH critical care patients should be escorted by the Grantham Consultant Anaesthetist or other appropriately trained and competent personnel as identified by the Consultant Anaesthetist on-call

18.4. Elective surgical patients who are identified at pre-operative assessment in Grantham as needing critical care will be booked as elective critical care admissions in the receiving hospital and transferred to Lincoln or Pilgrim sites for surgery in line with the Trust policy.

18.5. Leicester General Patients

18.6. Leicester General Hospital (LGH) is unique within the Network in providing acute medical services and elective in-patient surgical care with no on site level 3 critical care beds. The site does have a Level 2 unit (with the ability to provide Level 3 care for up to 24 hours) both for medical and elective surgical cases (Urology- elective and emergency including a busy acute urology take, planned orthopaedics and gynaecology). The LGH also contains a busy obstetric unit. Once a patient is identified as potentially requiring critical care beyond these limits then the LGH Consultant responsible for the patient should discuss the patient with the University Hospitals of Leicester (UHL) Critical Care Consultant on-call via switchboard (LRI or GGH). This contact is for clinical advice only. This Consultant to Consultant referral should include a discussion about the presentation of the patient, and accurate past medical history and co-morbidity status.

18.7. Once the patient has been discussed by the referring and ICU Consultants if it is deemed clinically appropriate to transfer the patient, the UHL Critical Care Consultant will identify the availability of critical care beds within the UHL Critical Care Units. If an ICU bed is available, the patient should be referred to ACCOTS (see section 30) to facilitate the transfer. Exception to this is where the patient's needs cannot be met within UHL (e.g. neuro or major trauma care) and the patient will need to be transferred to the most appropriate centre for on-going care or if the transfer is not for a time critical intervention but no ULH ICU bed is available, in which case an appropriate critical care bed within the Network should be identified via the ACCOTS co-ordinator. Where ACCOTS are unable to provide clinical assistance, transfer of LGH critical care patients should be escorted by the LGH Consultant Anaesthetist or other appropriately trained and competent personnel as identified by the Consultant Anaesthetist on-call

18.8. Elective surgical patients who are identified at pre-operative assessment in LGH as needing critical care will be booked as elective critical care admissions in the receiving hospital and transferred to the appropriate UHL site for surgery in line with the Trust policy.

18.9. For the avoidance of doubt, LGH would not be considered a suitable site to accept capacity transfer out from other ICUs. It would continue to accept the current repatriation / continued care" transfers from LRI and GGH.

18.10. Non-acute/Community Hospital sites

Within the Network there are a number of non-acute and community hospital sites where acute hospital Trusts may be providing elective surgical services. Appropriate arrangements should be in place for escalation of patients requiring critical care support from those sites to critical care units, in keeping with local Trust policy. The normal expected pathway for these patients would initially be in to the local acute Trust for stabilisation and ongoing treatment. In exceptional circumstances however, there may be a requirement to transfer patients to other critical care unit because of specific clinical needs or due to lack of local bed availability. Responsibility for ensuring appropriate transfer arrangements including access to transfer equipment and appropriately transfer trained staff rests with the referring Trust.

18.11. All critical care units will keep a record of all referrals, whether admitted, refused or postponed. A record will also be kept of premature discharges and re-admissions to critical care during the course of a single hospital admission.

19. Operational and Discharge Policy

(Standards in accordance with the Adult Critical Care Service Specification[18])

19.1 Protocols for the various aspects of medical and nursing care will be available in critical care ward areas and should be maintained in line with best evidence-based practice and appropriate national guidance. All staff including visiting or temporary staff should be aware of these protocols.

19.2 Each provider must have a designated Clinical Director/lead Consultant who should be a FFICM recognised Consultant in Critical Care Medicine, a matron/lead nurse and an advanced level pharmacist for Critical Care, all of whom should be actively engaged in their local Adult Critical Care Operational Delivery Network (ODN). Clinical pharmacists are essential practitioners within the critical care multi-professional team and are vital to the routine delivery in critical care practice of medicines optimisation.

19.3 Clinical care within critical care must be led by a Consultant in Intensive Care Medicine (as defined by the Faculty of Intensive Care Medicine).

19.4 A Consultant in Intensive Care Medicine must be immediately available 24/7 and be able to attend within 30 minutes, Consultants must be freed from all other clinical commitments when covering Intensive Care and this must include other on-call duties.

19.5 While the underlying philosophy remains that of shared care, management of critical care patients in critical care ward areas will be the responsibility of the critical care medical staff, headed by the Consultant on-call. For clarity of accountability, in areas of debate, the final decision will rest with the Critical Care Consultant. Referring teams should review patients within 12 hours of admission to critical care then on a daily basis or more frequently if desired. Recommendations of referring teams will be actively solicited.

19.6 The critical care medical staff will communicate significant changes in a patient's condition to the referring team.

19.7 All critical care patients will undergo a full daily review and clinical examination by the critical care staff and minimum twice daily critical care Consultant review 7 days/week in line with 7-day standards. This should include a full clinical examination and a review of the observations, chart, notes and investigations. The review and all significant interventions, verbal reports of results and other clinical events should be documented in the patient's records.

19.8 Visiting or temporary staff reviewing patients should also record their findings and the critical care medical staff will communicate significant changes in a patient's condition to the referring team. in the notes. Final decisions on day-to-day management rests with the Critical Care Consultant.

19.9 In addition, there should be multidisciplinary 7-day input available from the extended team (e.g. microbiology, pharmacy, physiotherapy and where applicable, dietetics and speech and language and occupational therapy).

19.10 Clinical pharmacists supporting delivery of medicines optimisation in critical care areas must provide patient-centred care, including: medicines reconciliation (on admission and

[18] NHS England, 2019. Adult Critical Care Service Specification (170118S). Available: https://www.england.nhs.uk/publication/adult-critical-care-services/

discharge), independent patient medication review with attendance of multi-professional ward rounds and professional support activities, including: clinical guidelines, medication-related clinical incident reviews and clinical audit and evaluation.

19.11 All providers must provide a minimum nursing establishment determined by the following nurse to patient ratio:

- Level 3 patients have 1:1 nursing ratio for direct patient care
- Level 2 patients have 1:2 nursing ratio for direct patient care

19.12 All Providers must provide a minimum medical staffing ratio per critical care bed as per the below:

- Consultant day time ratio 1:8 – 1:12
- Intensive care resident ratio 1:8

19.13 Each Critical Care Unit must aim to have a supernumerary shift clinical coordinator 24/7. Supported by an additional supernumerary clinical coordinator for every additional 10 beds.

19.14 Critical care staff supporting non-critical care areas

On occasion there may be staff shortages in other departments within the hospital and whilst this may normally be managed by the respective departments according to each Trust policy, there may be instances where this takes place out of hours resulting in management by the senior team on for the hospital. This can sometimes result in a request from another department to the critical care unit for a member of staff (nursing) to help the other department.

19.15 It is reasonable for critical care teams to support ward areas when requested when "overstaffed" in critical care, if other areas of the site are understaffed compromising the quality of patient care and patient safety.

19.16 The movement of staff from critical care to support other areas should not result in the closure of critical care beds/reduce critical care capacity or make the care of patients in critical care unsafe or fall below the quality standard levels defined in national standards and guidance[19] (A minimum 1 nurse per Level 3 patient, 1 nurse per 2 Level 2 patients plus a supernumerary shift co-ordinator. [20])

19.17 Under no circumstances should the movement of staff from ICU prevent the admission of a patient identified as requiring critical care support or result in the non-clinical transfer of a critically ill patient.

19.18 The decision on what represents safe vs unsafe staffing on ICU needs to be made by individuals who have the clinical knowledge and understanding of the provision of critical care and the current patient case mix and acuity in critical care at the time. That decision should be made based on the acuity and level of care of patients in critical care, any known admissions (i.e. patients currently in theatre or wards accepted for admission or accepted for transfer in from another site) and not simply based on current patient/nurse ratios. Risk assessment tools should be utilised appropriately.

19.19 GPICS 2 guidance[20] is very clear that the decision on the Critical Care Unit's ability to support requests for nursing staff to assist in other areas rests jointly with the nurse in charge and duty ICU Consultant who carry clinical responsibility for the care of patients in critical care and those patients outside of critical care who require critical care admission. Those clinician-based decisions should not be overridden by operational management teams.

19.20 If staff are available to be moved from critical care to other areas, it must be on the understanding that robust arrangements are in place to allow those staff to return to ICU immediately should the need arise. This may be due either to the need to admit a new patient(s) to critical care or because of escalations in level of care of existing patients.

19.21 Critical care staff moved to other areas should only be expected to work within their levels of competence and experience. This may preclude critical care staff undertaking some specific roles, working in specific speciality areas or from acting as ward or bay co-ordinators depending on the skills and experience of the individuals concerned.

19.22 If the guidance is breached this should be reported through that Trusts governance and risk management processes (incident reporting system) and the Network informed of a breach in operational policy.

19.23 Nursing staff should be supported by an appropriately sized critical care educational team in line with current national standards. There must be appropriate access to a Clinical Nurse Educator (CNE) with CNE time based on overall nursing numbers.

19.24 There must be a training strategy in place to achieve a minimum of 50% of nursing staff with a post-registration award in critical care nursing in all units where this is not maintained.

19.25 Relatives of a critical care patient should be kept fully informed of the patient's condition and any formal interviews should be recorded, together with their views and questions and the explanations offered by staff. Discussion with relatives by referring teams should only occur once they have familiarised themselves with the content of previous discussions and should be well documented and should take place with a member of the critical care nursing or medical team in attendance.

---

[19] NHS England, 2019. Adult Critical Care Service Specification (170118S). Available: https://www.england.nhs.uk/publication/adult-critical-care-services/

[20] The Faculty of Intensive Care Medicine, Intensive Care Society, June 2019. Guidelines for the Provision of Intensive Care Services Edition 2. Available from: https://www.ficm.ac.uk/sites/ficm/files/documents/2021-10/gpics-v2.pdf

19.26 All discussions between the family and a doctor should take place in the presence of a member of the critical care registered nursing staff.

19.27 Patients in whom critical care therapy is only prolonging the process of death should receive compassionate care as any other course of action constitutes inhumane treatment. Compassionate care should be instituted only after the views of the referring team and the relatives have been obtained. If, however, there is a major disagreement, the advice of another Critical Care Consultant can be sought, and their advice should be accepted. In all cases, the final decision rests with the critical care medical staff as it is a medical critical care decision.

19.28 Patients will usually be discharged from the critical care area to an appropriate bed on a specialty specific ward/ward of the referring Consultant. The possibility of discharge will be discussed with the team accepting care as soon as it becomes apparent.

19.29 Discharge from critical care to ward level care must occur within 4 hours of the decision to discharge (declared medically fit for discharge and bed management team informed in line with current national guidance). It is extremely important that all efforts are made by the accepting/bed management teams to find a bed as soon as possible since it is neither clinically or financially acceptable to maintain a patient in critical care once deemed fit for discharge.

19.30 If there is a delay, this should be escalated through agreed Trust process and be recorded as such and reported to the Network in accordance with the agreed process[21] (currently via DOS). If, due to delayed discharge, clinical care of patients is compromised, admission of patients to critical care, emergency, or elective is delayed, or non-clinical transfers may be needed, this should be escalated to a senior executive level within the Trust.

19.31 Discharge from critical care to a ward must be formalised by both written and verbal handover to the ward team. The handover must satisfy the requirements in NICE Clinical Guideline 50[22] and demonstrate progress towards compliance with NICE Quality Standard 83.[23]

19.32 Discharge of patients home directly from critical care units is recognised as undesirable and should only be undertaken in exceptional circumstances. On rare occasions this may be appropriate for patients requiring short term critical care support to maintain normal pre-hospital level of care i.e. home ventilation/CPAP. If patients are to be discharged home a pre-discharge review by the parent speciality to complete discharge planning and make appropriate follow up arrangements must occur on the day of discharge.

19.33 The transfer to the ward must take place between 0700hrs and 2159hrs (ideally between 0700hrs and 1959hrs).

19.34 Only in exceptional circumstances (e.g. surge) should a transfer to the ward take place outside of these hours. If an 'out of hours' transfer is required (2200hrs – 0659hrs), this should be recorded and reported to the Network in accordance with the monthly benchmarking data sharing.[24]

19.35 Discharge may be necessary before clinically optimal, in times of bed shortage, and in this case the decision of the Consultant in charge of critical care is final.

---

[21] NHS England, 2019. Adult Critical Care Service Specification (170118S). Available: https://www.england.nhs.uk/publication/adult-critical-care-services/
[22] NICE, 2007. Clinical guideline [CG50]. Acutely ill adults in hospital: recognizing and responding to deterioration https://www.nice.org.uk/guidance/cg50
[23] NICE, 2009. Clinical guideline [CG83]. Rehabilitation after critical illness in adults https://www.nice.org.uk/guidance/cg83
[24] NHS England, 2019. Adult Critical Care Service Specification (170118S). Available: https://www.england.nhs.uk/publication/adult-critical-care-services/

19.36 Patients undergoing specialist care should be repatriated to an appropriate Trust closer to their home when clinically appropriate to continue their re-ablement. Such discharge should occur within 48 hours of the decision to repatriate and the decision to repatriate should not be a reason to delay discharge from critical care to a ward bed.

19.37 Each Critical Care Unit must submit capacity data at least twice a day to the national Directory of Services bed management system.[25] Critical care services must have an effective clinical governance platform and robust data collection system. This must encompass:

19.37.1 Participation in national audit programmes for Adult Critical Care (the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme, including patient reported outcome measures (PROMS) when available

19.37.2 Public Health England Infection in Critical Care Quality Improvement Programme (ICCQIP), including the nationally agreed dashboard. Note: The Standardised Mortality Ratio is included in this dashboard.

19.38 Providers of critical care are required to participate in activities of the Unit's local ODN for Adult Critical Care, including peer review/assurance process.

20. Intensive Care Clinical Governance

20.1 Each Trust within the Network has an identified critical care clinical governance lead that is key to ensuring clinical governance implementation. The Network has a Clinical Governance Framework, which includes monitoring of critical incidents such as non-clinical transfers, elective operations taking place without planned critical care resources and health and safety issues.

20.2 With regard to clinical governance in a clinical network environment, whilst the Network (as a non-statutory organisation) does not have any formal responsibility for patient care, the Network does have a responsibility for the wider system, in terms of assurance and enabling standards, to make sure that the Network functions safely.

20.3 Critical incidents should be reported via individual Trust mechanism. Where incidents have implications for the wider Network, they should be reported to the Network via the Critical Care Related Events Database (CCRED)[26] as a matter of urgency and any actions raised initially at the CCRED Discussion Meeting with escalation to the Network Clinical or Lead Nurse group meetings as appropriate. High-risk issues, which are common across the Network, will be raised at the Network Board meeting following consultation with both the Clinical and Lead Nurse Groups.

20.4 The Network has previously provided training for representative members of staff from each Unit in Root Cause Analysis. Should expert input be required by individual Units/Trusts this can be made available as requested through the Network Management Team.

20.5 All Units should be working towards compliance with NICE Clinical Guideline 83[16] and Quality Standard 158.[27] As a minimum, this should include having benchmarking data and a 'SMART' action plan in place to:

20.5.1 demonstrate effective implementation of evidenced based practice within Intensive Care Medicine

---

[25] NHS Digital. NHS Pathways Directory of Services (DoS) https://www.directoryofservices.nhs.uk
[26] Access via https://forms.office.com/e/kq0BCvyWyF
[27] NICE, 2017. Quality standard [QS158] – Rehabilitation after critical illness in adults. Available from: https://www.nice.org.uk/guidance/qs158

20.5.2 evidence effective engagement with patients and their families and carers

20.5.3 demonstrate that they have a risk register in place together with an associated audit calendar which is regularly updated and acted upon have effective strategies in place to minimise hospital-acquired infections within Critical Care and publish central venous catheter-related blood stream infection rates

20.5.4 demonstrate avoidance of readmission to Critical Care (ICU and HDU) within 48 hours of discharge

21. Notification of General Practitioners

21.1. The patient's General Practitioner (GP) is to be informed by telephone (or secure electronic communication or letter sent on the day of admission) of the admission of the patient to critical care and within 24 hours of the death of a patient in critical care (again by telephone, secure electronic communication or letter). A written notification the event of discharge or death should be completed within 24 hours. Arrangements should be in place for GPs to obtain further details of patients care and treatment within the critical care unit if this is requested.

21.2. In the case of transfer between critical care units, the referring hospital should be responsible for notifying the patient’s GP of the transfer. Should the patient die, the hospital where death occurs should, as soon as possible after death, notify the patient’s GP to assist the GP in supporting the family.

22. Organ Donation

22.1. All critical care units should support and facilitate the identification of people with the potential to donate their organs after their death in line with NICE Clinical Guidance.[28] Organ Donation should be considered a normal part of end of life planning on the ICU. This should include the early referral of all patients (where withdrawal of life sustaining treatment is intended) to specialist organ donation services and the multidisciplinary, collaborative approach including specialist nurses for organ donation to patients, families and carers to gain support for organ donation unless this would go against decisions previously made by the patient (e.g. if the patient has opted-out as per current legislation). For clarity, it the patient’s family or carers object, the donation cannot proceed.

22.2. Identification of potential for organ donation should be triggered in patients who have had a catastrophic brain injury (the absence of cranial nerve reflexes and a GCS of 4 or less not explained by sedation and/or a decision to perform brain stem death tests), or the intention to withdraw life sustaining treatment in patients with a life threatening/ life limiting condition that is expected to result in circulatory death.[27]

22.3. Ongoing critical care should be provided whilst these considerations are explored and in cases where consent is agreed and proceeding to organ donation is planned.

[28] NICE, 2011. Clinical guideline [CG135]. Organ Donation for Transplantation: Improving Donor Identification and Consent Rates for Deceased Organ Donation. Available from: https://www.nice.org.uk/guidance/CG135

23. Major Incident/Mass Casualty/Pandemic

23.1. At times of major incident, some of the above Policy may be modified in accordance with the Major Incident Plan of the hospitals involved. If a hospital in the Network activates its Major Incident or Mass Casualty Plan, it should notify surrounding Units in the Network. This can be by either direct contact or via the Network. In the event of a Major Incident being declared, the initiating Trust (T1) will evoke their Major Incident Policy. T1 then informs its Unique Transfer Group and they thereafter stop all elective ICU admissions (i.e. from Theatre lists).

23.2. Medical support for the Ambulance Service in the event of a Major Incident will be coordinated by the Emergency Operations Centre (EOC) of EMAS using the Medical Incident Advisor (MIA) rota. Each Ambulance Control must mutually inform neighbouring controls of any declared major incidents in line with the Ambulance Trust Major Incident/Mass Casualty Plan.

24. Network Bed State

24.1. Each Unit will as soon as is practicable after patient admission and discharge, update the national NHS Pathways Directory of Services (www.directoryofservices.nhs.uk) to facilitate inter-Unit transfer when such is required. In addition, the accuracy of the bed state will be checked at twice daily intervals. Units are requested to update the Directory of Service bed state at twice a day (during times of surge a request will be made for more frequent updates depending on the situation).

24.2. In times of heightened demand, the Network may run a morning capacity call to support updates of bed states and decision making. When these are operational it is expected that units send a representative who can provide an update on the unit's bed state and current issues.

25. Bed Closures Baseline

25.1. An indicator of bed closures is included in the Network Benchmarking Measures document and recorded monthly. Each Unit should have a local policy for closing critical care beds under any circumstance. These local policies should be developed and then monitored by the Unit teams and also Trust Critical Care Delivery Groups (or other such Group) to ensure that beds are re-opened as soon as possible in order to ensure equity of access. The Network should be notified of any bed closures via the national NHS Pathways Directory of Services and via communication to the Network Office and any prolonged closures should be discussed with the Network Management Team. The Network Board will review Unit bed closures every 6 months and when a Unit needs to close beds for a prolonged time period, the funding implications of such closures will be discussed with the Board commissioners.

26. Independent Providers

26.1. Patients who are entitled to NHS care, where initial treatment is provided in the private sector have the same rights of access to NHS critical care support in the event of an emergency as any other NHS patient. In an acute clinical emergency, treatment should not be delayed while entitlement to free NHS care is determined and all patients should be treated according to clinical need.

26.2. The national critical care service specification[29] requires private sector critical care providers to be members of their regional critical care operational delivery network. Private providers are also required to have appropriate agreements with NHS Trusts to facilitate access to critical care facilities and transfer processes in the event of an emergency requiring ongoing critical care support.

26.3. In addition, the Network works in partnership with the Independent Sector – although it is recognised that in the main, the Independent Sector is a net exporter of patients to the NHS. Through collaborative and partnership arrangements however, there may be opportunities for improved patient care, staff training accessible to all partners and access to private critical care facilities in the event of a major critical care surge.

26.4. The current flow of patients is predominantly from the private sector to the NHS. As partners in the Network, independent providers will be kept aware of the Network bed state and be expected to avoid the risk of adding to Network pressures at times of pressure on the Network bed pool. This may include requests to modify the profile of operative practice. Where applicable, Independent Sector providers are required to update the relevant section of the NHS Pathways Directory of Services in line with regional agreement.

26.5. In the event of a non-time critical transfer of a patient from the Independent Sector to an NHS Critical care provider, it may be appropriate for NHS transfer equipment to be utilised via individual private provider/Trust Transfer Specification Agreements to ensure safe patient care (please see relevant section of Network Transfer Policy).

26.6. In the event of a time critical transfer e.g. post cardiac arrest, a normal EMAS 999 response should be requested and the patient transferred on the ambulance cot with monitoring via the EMAS Lifepak.

26.7. Transfers from the Independent Sector to the NHS will be regarded as clinical emergencies. Private providers will transfer to the closest appropriate critical care bed within their Unique Transfer Group. Agreement by private providers to the operational policy and their Unique Transfer Group will take place of formal contracts previously recommended by the Independent Healthcare Confederation.

26.8. Individual Trusts are responsible for planning for the possible use of independent sector beds and facilities to manage elective capacity. In the event of Network wide surge, potential use of private sector critical care bed capacity would in the first instance be facilitated by the Network.

26.9. The Network and individual NHS provider trusts have agreed with Independent Providers (via a specification agreement) protocols to facilitate safe transfer of critical care patients from the Independent Sector to the NHS (these specification agreements must be adhered to for the transfer of critically ill patients). This is to ensure that the safety of the patient is the primary concern and overrides other factors such as the NHS base of the surgeon or physician, where this does not correspond with the nearest available critical care bed.

26.10. In addition, following national guidance for critical care providers to be a member of an Operational Delivery Network to ensure that non-clinical transfer of patients in organised in a managed way, each critical care/acute provider is to agree a group of hospitals with whom they will liaise in ascending order to establish if a critical care bed is available in the event of a transfer being required. For the purposes of this policy, the group of hospitals is defined as those within the East Midlands Adult Critical Care Operational Delivery Network.

[29] NHS England, 2019. Adult Critical Care Service Specification (170118S). Available: https://www.england.nhs.uk/publication/adult-critical-care-services/

26.11. It is the intention to agree with each Independent Provider the Unique Transfer Group for their Unit, which will need to take into account the closest NHS acute hospital.

27. Quotient Sciences

27.1. The Network will be informed as to the nature of any planned studies at Quotient Sciences. In the event of an emergency occurring, the Quotient clinical staff will follow the ALS guidelines for the immediate care of the subject and will additionally call 999 to arrange transfer of the subject to the most appropriate facility. A member of Quotient clinical staff will accompany the subject in the ambulance to facilitate handover at the receiving hospital. Following the 999 call, the Network will be contacted to notify them of the emergency situation.

28. Complaints

28.1. In the event of any clinical or administrative difficulties not covered by this policy or solvable by other means, the East Midlands Critical Care Network Medical Lead and the Medical Director of the Hospital shall be asked to resolve the issue

28.2. In the event of patient, relative or service user complaints regarding clinical critical care services, Trust complaints procedures should be followed, as individual trusts retain clinical responsibility for critical care patients at all times.

28.3. In the event of complaints about the conduct of the Network or its employees, these should be directed to the Senior Network Manager or Network Chair as appropriate.

29. Interdependence with Other Services

29.1 Co-located services - provided on the same site so that they are immediately available 24/7:

- General Internal Medicine
- Radiology: CT, ultrasound, plain x-ray
- Echocardiography/ECG
- General surgery (for any site with general surgical admissions)
- Transfusion services
- Essential haematology/biochemistry service and point of care service
- Physiotherapy
- Pharmacy
- Medical Engineering Services
- Speciality Intensive Care Units must have their speciality specific surgical service co- located with other interdependent services, e.g. vascular surgery with interventional vascular radiology, nephrology and interventional cardiology; obstetrics with general surgery
- Access to theatres and a competent resident clinician (Anaesthetist/Intensive Care Medicine) with advanced airway skills should also be available 24/7 along with informatics support.

29.2 Interdependent services- The following 24/7 services need not be co-located on- site, but service level agreements should specify response times for these specialities which will range from being available within 30 minutes to a maximum of 4 hours, dependent on the case mix of the patient population:

- Interventional vascular and non-vascular radiology
- Neurosurgery
- Vascular surgery

- General surgery (only applies to a site which does not admit general surgical patients)
- Nephrology
- Endoscopy
- Coronary angiography
- Cardiothoracic surgery
- Trauma and orthopaedic surgery
- Plastic surgery
- Maxillo-facial surgery
- Ear, Nose and Throat surgery
- Obstetrics and gynaecology
- Organ donation services
- Acute/Early phase rehabilitation services
- Additional laboratory diagnostic services

29.3 The following services should be available during daytime hours (Monday – Sunday):

- Occupational therapy
- Dietetics
- Speech and language therapy
- Bereavement services
- Patient liaison service

29.4 Related services – following the critical care phase of the patient journey:

- Local hospital and community rehabilitation services
- Specialised rehabilitation services
- Critical care follow-up
- Clinical psychology
- Spinal cord rehabilitation services
- Primary care
- Burns services (Burns Network)
- Voluntary support services

29.5 Relationship with Operational Delivery Networks

Critical Care ODNs fulfil several roles including:

- Supporting providers with knowledge, expertise and practical support to redesign their services; enhancing patient safety; patient experience and partnership working.
- Supporting commissioners in the delivery of their commissioning functions, for example:
  - providing peer review functionality;
  - assisting with service redesign/delivery;
- Supporting quality improvement initiatives;
- Providing local knowledge to support funding models and commissioning intentions inherent in their Integrated Care System's (ICSs) plans where expertise and funding exists
- Their role is also increasingly relevant to supporting the very small number of geographically remote critical care units (there are 16 providers with an average distance of 80 km from a neighbouring unit) to develop a service model that maintains equity of access and breadth of service for their population and provides sustainable solutions for these rural units.
- Assisting providers and commissioners in the delivery of their Emergency Preparedness, Resilience and Response (EPRR) plans

30. Transfer Policy

***[Point to note:** Within the Network region, the Adult Critical Care and Co-ordination Service (ACCOTS) is the main transport provider. East Midlands Ambulance Service (EMAS) acts as provider of last resort in the sense that if ACCOTS is unavailable and a time critical transfer is required then they will be contacted, Additionally, the West Midlands Ambulance Service (WMAS) and West Midlands Air Ambulance/Helimed also serve Burton Hospital and Burton is advised to liaise with these services as appropriate. This Policy includes reference to the national Framework to support inter-hospital transfer of critical care patients[30] and equipment and processes relating to EMAS.]*

30.1. All acute provider Trusts must have arrangements in place to ensure that transfers for capacity reasons alone (non-clinical transfers) occur only as a last resort. It is however recognised transfer of a critical care patient to a critical care ward in another hospital may sometimes be necessary. Where necessary, transfer should be to the most appropriate hospital for the clinical needs of the patient, while taking account of bed availability, transfer distance, and transport capacity. All relevant parties, including the relatives, should be informed that the transfer is taking place. Please see Principles for ACC Mutual Aid via ACCOTS under Appendix C Critical care transfers should be undertaken in keeping with the latest ICS Guidance on the Transfer of the Critically Ill Adult.[31]

30.2. All Network hospitals should nominate a lead clinician for critical care transfers with responsibility for guidelines, staff training, competencies, and equipment provision. This individual should report to the Trust critical care delivery group/governance meeting and Network Transfer Audit Group.

30.3. All Network hospitals must have systems and resources in place to resuscitate, stabilise and transport critically ill patients when required. Plans should encompass all critical care areas including intensive care and high dependency care areas, acute wards and emergency departments.

30.4. Patients should be appropriately resuscitated and stabilised prior to transfer to reduce the physiological disturbance associated with movement and reduce the risk of deterioration during the transfer. In the case of transfer needed to manage clinical demand (non-clinical transfers) the Network supports the policy of transferring the most stable appropriate patient in order to minimise the risks of transfer.

30.5. Transfer for immediate lifesaving interventions must not be delayed by lack of availability of a critical care bed.

30.6. All critical care transfers (level 2 or 3) from ANY location (ICU, theatre, emergency department) should be referred to the ACCOTS service, either via the ReferaPatient system for non-emergency transfer or via the Single Point of Contact number – ***0300 200 1100*** for time-critical transfers. Please refer to the Referring to ACCOTS SOP. Appendix D.

30.7. All acute hospitals responsible for transferring critically ill patients must have access to a CEN compliant transfer trolley and appropriate transfer equipment. To facilitate Network wide training, standardised Network approved transfer trolleys and equipment should be utilised whenever possible. ACCOTS and Networks equipment will be aligned. All monitoring and equipment must be suitable for use in the transfer environment and mounted on the transfer

---

[30] NHS England, 9th December 2021. Framework to support inter-hospital transfer of critical care patients https://www.england.nhs.uk/publication/framework-to-support-inter-hospital-transfer-of-critical-care-patients/
[31] The Faculty of Intensive Care Medicine, Intensive Care Society, May 2019. Guidance On: The Transfer of the Critically Ill Adult. London

trolley in such a way as to be CEN compliant Equipment must be serviced, maintained and checked prior to use in such a way as to reduce the risks of failure during transfer.

30.8. Patients should be securely strapped to the transfer trolley by means of a 5-point harness (or similar). Reassurance, sedation, analgesia and anti-emetics should be provided as required to reduce patient discomfort and distress and all portable equipment must be securely stowed to reduce the risk of injury in the event of an accident.

30.9. In the event of transfers between NHS Units, where ACCOTS clinical team are unavailable, the referring Unit must provide staff with the required training skills and competencies to undertake the transfer. Staff without the appropriate training and competencies should not undertake unsupervised transfers.

30.10. The patient should be accompanied by a critical care nurse or appropriately skilled assistant trained in transfer, (i.e. critical care nurse, ODP or Emergency Department nurse) and a doctor or other practitioner, preferably a critical care doctor, an Anaesthetist or FICM registered Advanced Critical Care Practitioner (ACCP) with appropriate training and skills and experience. Transferring staff should have the appropriate competencies and be familiar with the current transfer equipment. Best practice is for all escorting staff to have transfer training with a minimum of one escorting staff being transfer trained.

30.11. The decision to transfer and to accept a patient must be made by appropriate consultants in both the referring and receiving hospital, this will be facilitated by the ACCOTS co-ordinator. Any inter-hospital transfer of a critically ill patient requiring on going critical care support should only be undertaken after discussion with, and in agreement by, the on-call consultant or critical care.

30.12. Prior to the transfer of a critically ill patient, a risk assessment should be undertaken and documented by a senior clinician to determine the level of anticipated risk during transfer. The outcome of the risk assessment should be used to determine the competencies of the staff required to accompany the patient during transfer.

30.13. Repatriation policies for patients who no longer require specialist care should be agreed across networks. Patients who require repatriation must be transferred within 48 hours of being identified as suitable for repatriation. It is expected that once a patient has been transferred to another critical care unit they will not be repatriated until stepped down from the critical care unit. The only exception may be where the receiving critical care unit requires decompression and the patients home unit has an available bed.

30.14. Patients and their relatives should be kept informed at all stages of the transfer process and should be provided with appropriate written information. Please see “Information for Relatives Regarding Transfer” in Appendix E.

30.15. Transfer of critical ill patients to the NHS from the independent sector are subject to the same standards and guidance as NHS transfers and will also require appropriately trained transferring staff and this is the responsibility of the referring private sector provider. Provision of dedicated transfer equipment may be by private providers themselves or via transfer specification agreements with designated NHS Acute Trusts.

30.16. ACCOTS will provide a suitable vehicle and driver, plus a clinical team as available. If not available, the ACCOTS co-ordinator will communicate this clearly and themselves request the ambulance service to support the transfer.

30.17. If ACCOTS is unable to support, the ambulance service will provide a suitable vehicle and driver with an assistant familiar with the internal layout of the vehicle. In normal circumstances a NHS 999 vehicle with an Anderson connector with either Emergency Care Assistant (ECA) or an ECA/technician crew will be provided. At times of increased demand, a third-party provider may be asked to provide the transport platform in which case spade connectors can be used to power the transfer trolley if required. It remains the responsibility

of each critical care unit to ensure that the transfer trolley and equipment is maintained and charged prior to each transfer.

30.17.1. Provision of EMAS ambulances for critical care transfers will be in-line with the agreed EMAS Inter-Facility Transfer (IFT) National Framework (Appendix G). Inter-Facility critical care transfers will normally be treated as IFT2 priority transfers unless otherwise mutually agreed.

30.18. Monitoring and management during the transfer should maintain the same standard of care as in the referring critical care unit. This includes the recording of monitored variables and significant events. Monitoring should be continuous throughout the transfer. All monitors, including ventilator displays and syringe drivers should be visible to accompanying staff.

30.19. The Midlands Critical Care Network transfer form Appendix F should be used for the recording of patient care during transfer to ensure an appropriate record of clinical care and that all patient transfers are subject to audit, critical incident reporting and review including analysis of feedback from patients and relatives.

30.20. Staff should remain seated at all times and wear the seat belts provided. If it is necessary to attend to the patent during transfer, the ambulance crew should be informed, and the vehicle stopped in a safe place. High speed journeys must be avoided except where clinically necessary. Blue lights and sirens may be used to aid passage through traffic to deliver a smooth journey.

30.21. Full patient records, either originals or photocopies including nursing documentation and prescription records must accompany the patient. On arrival in the receiving Unit all drug infusions must be made up using the normal concentration and administration methods of the receiving Unit to avoid errors in dosage.

30.22. The normal pattern of transfer will reflect current pathways and Unique Transfer Groups of each individual critical care unit.

30.23. Where, due to lack of local diagnostic facilities, a transfer for CT scanning or other emergency diagnostic imaging is required to establish diagnosis and plan appropriate treatment:

- The patient will remain the overall clinical responsibility of the referring hospital and its transfer team until formal transfer of care is agreed at the tertiary care centre.
- An ambulance for the transfer for imaging will be booked with ACCOTS or EMAS if ACCOTS is unavailable on a “return journey” basis – i.e. if it is ultimately determined that the patient should not be transferred to tertiary care, the patient will be returned to the originating hospital after imaging.
- The transferring team will hand over responsibility for immediate clinical management to the imaging hospital medical team during the scanning process, but the transferring team remain in case the patient requires return to the original hospital. Full handover of care to a receiving speciality or team in tertiary care will depend on the results of imaging and the need for further intervention.
- The transferring hospital, in addition to arranging imaging at another hospital, will notify the potential receiving speciality and the critical care team at the hospital which would be expected to accept the patient for further treatment.

If a critical transfer is not be undertaken by ACCOTS – need to be called through ACCOTS coordinator (all need to go through ACCOTS system) or if the transfer is not being undertaken by an ACCOTS team the transfer should still be documented using the Midlands Critical Care Transfer Form (Appendix F) which should remain with the patient as part of their record. Any significant incidents during transfer should be reported

through Transferring Trusts DATIX system, and using the Midlands Critical Care Related Incident

30.24. Any decisions regarding RESPECT/Do Not Attempt Resuscitation (DNAR) orders should be made a priority by the Consultant arranging the transfer before the patient leaves the referring hospital. All relevant RESPECT DNAR documentation should be completed in advance of the transfer and secured within the patient's medical notes. All members of the transfer team (registered nurse, doctor) should be made aware of the patient's DNAR status prior to the transfer.

30.25. If a patient with a DNAR order in place suffers cardio-respiratory arrest in transit, there will be no requirement to stop the ambulance and perform CPR.

30.26. If a patient who is not DNAR suffers a cardio-respiratory arrest in transit, the decision to stop the ambulance in order to perform CPR will be made by the doctor from the transferring hospital present in the vehicle.

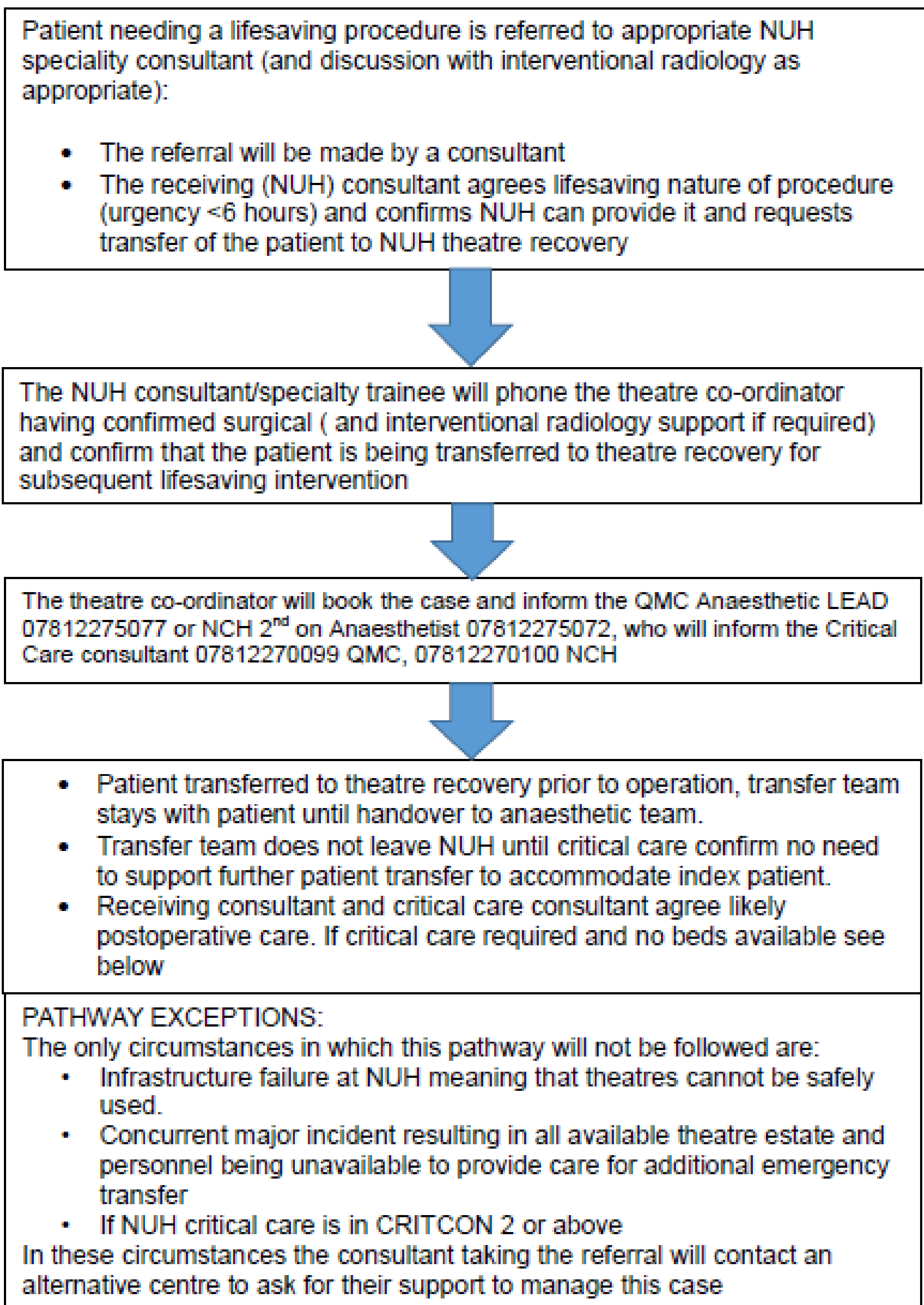
30.27. The senior clinician in the ambulance, in consultation with the team on board, will be responsible for any subsequent decisions regarding DNAR status, in the face of ongoing or prolonged resuscitation requirements, based on the patient's clinical presentation at the time of the event. The patient will not be subject to inappropriate resuscitation measures in the ambulance where further attempts may be futile.

30.28. If a patient dies during the transfer, the body should be returned to the referring hospital, which should be notified by mobile-phone immediately. The referring hospital should also notify the receiving hospital.

30.29. On return to the hospital, the body should either go to the mortuary or a predefined bed area either in the Emergency Department or elsewhere. Either an appropriate bed area or the Chapel of Rest can be used to allow relatives to visit.

30.30. Transfer of a patient into a Trust, closer to their home, to continue their re-ablement following specialist critical care should occur within 48 hours of the decision to transfer, as per national standard.

Appendix A - Pathway for the referral of patients requiring lifesaving surgery/intervention at NUH



Appendix B – Framework to Support Inter-Hospital Transfer of Critical Care Patients (B1215)

Appendix B -
B1215_Adm & Op Po

Appendix C - Principles for ACC Mutual Aid via ACCOTS

Appendix C -
Principles for ACC Mu

Appendix D – Referral to ACCOTS

Appendix D -
Referring to ACCOTS

Appendix E - Information for Relatives Regarding Transfer

Appendix E -
Information for Relati

Appendix F – Example Network Transfer Form

Appendix F -
Midlands Transfer For

Appendix G - Network Wide EMAS Ambulance Transport Booking Procedure

The following section outlines the ambulance transport booking procedure – illustrated at Appendix G1.

Step 1 Urgency of Response

Time scale options:

Inter-Facility Transfer Level 2 (IFT 2) **Immediately Life, Limb or Sight (globe trauma) Threatening - 18- minute mean response time** (lights and sirens) response to the requesting Unit.

Inter-Facility Transfer Level 3 (IFT 3) **Additional Clinical Management - Within 2 hours response** [includes options for both 1 or 2-hour response time where commissioned]

Inter-Facility Transfer Level 4 (IFT 4) **All other non-emergency – Within 4 hours response.**

N.B. Inter-Facility Transfer Level 1 (IFT 1) is ONLY intended to be used for transfer to acute hospital sites from healthcare facilities with no capability for immediate advanced life support or ongoing resuscitation - it should not be used or requested for any transfer between acute hospital sites

Note that when EMAS is in Capacity Management Plan (CMP) 3 or above, non-clinical, and repatriation requests would normally be refused so please explore alternative means of discharging patients from your Unit.

The above response standards are from time of call to the arrival of the Ambulance at the Unit requesting transport for either collection of the patient or Hospital Team/Retrieval Team. It may also be important for the Unit booking the Transport to also specify a time that the patient must be at the destination hospital if this is time critical.

IFT 2 Immediately Life, Limb or Sight (globe trauma) Threatening - 18- minute mean response time (lights and sirens) should only be used for exceptional clinical conditions e.g.

- Neurosurgery (e.g. extradural, subarachnoid haemorrhage)
- Vascular surgery (e.g. leaking aortic aneurysm or limb threatening ischaemia) Primary or Rescue coronary angioplasty (PPCI)
- Paediatric sepsis or emergency not involving dedicated retrieval teams
- Major trauma treatment or management (e.g. transfer to Major Trauma Centre) Stroke transfer for thrombolysis /Thrombectomy
- Obstetric emergencies requiring immediate operative intervention (e.g. foetal distress) Emergency cardiac or cardiothoracic surgery included IABP transfers
- On-going critical care support that cannot be provided at the referring hospital site

IFT 3 level response (within 2 hours) would be the normal expectation for non-clinical Critical Care Transfers (i.e. transfers to create local capacity for emergency admissions)

IFT 4 level transfers would be the highest expectation for repatriation and only for repatriation of level 3 critical care patients (repatriation of patients below level 3 critical care supported would be provided by local trust arrangements for PTS-patient transport services)

1. **Contact EMAS Control on 999**. Units should ensure that they have access to a direct dial telephone in order to book Immediate Time Critical transfers.
2. When answered, state that you have an **"Inter Facility Transfer Level 2" from (e.g. Nottingham City) to (e.g. Lincoln County).**
3. A series of questions will be asked by the Ambulance Control staff which must be answered by the person making the call (irrespective of the level/grade of the caller) e.g.

"Tell me exactly what's happened…does the patient's condition present an immediate threat to life?"
"Is this call a result of an evaluation by a Clinician?". Age, sex conscious and breathing queries will be asked.
"Will any special equipment be necessary?"
"Will additional personnel be necessary?"
"What's the name of the referring doctor?"
"What's the name of the responsible nurse"
"Is the patient ready?" (Reminder given that if patient is not ready within 15 minutes of the
crew's arrival, the crew will withdraw, and the transfer will need to be re-booked)
"Does the patient have any known infections?"

Closure of call.

It is stated that if the patient's condition deteriorates whilst waiting for the ambulance to call back immediately.

If you experience any difficulties during the booking procedure, ask to speak with the Duty Manager immediately.

This procedure has been devised to ensure an immediate response to those rare situations when such a response is warranted. Please ensure that it is used only when appropriate and not just to secure a vehicle and crew. Please note that the response to these requests will be the next available crew, which may be two Emergency Care Assistants (ECAs) or technicians. Inappropriate requests for a paramedic escort will delay the provision of a vehicle, degrade EMAS' 999 response and may push the transfer request down the "stack" resulting in the patient spending an unacceptable amount of time waiting on the transfer trolley.

Please note that some 999 responses may allow a pre-emptive alert call to be made.

Where the 999-response option is to be used but the team are still preparing the patient, staff are asked to telephone Ambulance Control on **0115 9675099** to make the Ambulance Service aware of the need to start finding an appropriate vehicle for the forthcoming immediately life, limb or sight (globe trauma) threatening transfer.

It is envisaged that this would be done whilst the team are in the final stages of preparing/stabilising the patient approximately 20-30 minutes before making the immediately life, limb or sight (globe trauma) threatening request. This call is to alert the Control of an impending emergency transfer and is not to book the transport at this stage.

Only the briefest details are required when making the call:

- Name of the Unit
- Destination of patient
- Any specific requirements

No booking details will be taken by Control, but it will allow the Control Dispatcher to start planning the transport whilst waiting for the immediately life, limb or sight (globe trauma) threatening call to be made.

Courtesy calls for Long-distance/Out of Area (IFT 3 & 4)

Where it is known that the destination is over 75 miles outside of the Region it would be useful to make this known to the Control Dispatcher as early as possible to allow appropriate resources to be reserved for the journey. The details listed above should be provided during the courtesy call. Only in exceptional circumstances are the regional air ambulance services likely to be able to assist with such transfers. If this is considered a possibility then this should be highlighted to EMAS control who will liaise with the relevant air crew to be able to advise further.

Independent sector transfers

Patients who are entitled to NHS care, where initial treatment is provided in the private sector have the same rights of access to NHS critical care support in the event of an emergency as any other NHS patient. In an acute clinical emergency, treatment should not be delayed while entitlement to free NHS care is determined and all patients should be treated according to clinical need.

In the event of a transfer being required from an independent sector critical care facility, the relevant booking procedures as above should be followed. Specification agreements are in place with independent sector organisations in the Network which outline transfer arrangements between The Independent Sector Hospital, EMAS, the nearest identified Acute Hospital Trust and the Network. These specification agreements should be adhered to in the event of a critical care transfer. The Independent Sector hospital needs to ensure that they have a process in place whereby they inform the Ambulance Trust that prior to arriving at the independent sector hospital to transfer the patient they need to collect a critical care transfer trolley. When calling ambulance control, state that the transfer is a “time critical transfer”.

Ambulance Control must be informed that the relevant transfer trolley, without a team must be collected from the agreed NHS facility, this may NOT be the Unit that will be receiving the patient as per individual specification agreements.

In the event of a time critical transfer, there may be a requirement for patients to be transferred from the Independent Sector hospital to an Acute Hospital in the Network without the use of the critical care transfer trolley i.e. if the patient requires urgent surgical intervention. In this instance normal EMAS 999 ambulance booking procedures apply.

Step 2 Call to book the Ambulance (all priorities)

Dial 999 for Immediately Life, Limb or Sight (globe trauma) Threatening Transfers. State an Inter- Facility Transfer (IFT) Level 2 Immediately Life, Limb or Sight (globe trauma) Threatening is required.

Telephone 0115 97675099 for IFT Level 3 and 4. State which priority response is required.

- **IFT Level 2** (18 Minute mean response time – Life, limb or Sight [globe trauma] Threatening)
- **IFT Level 3** (Within 2 hours response [includes options for both 1 or 2-hour response time where commissioned]– Not immediate life or limb saving intervention, immediate capacity transfers)
- **IFT Level 4** (Within 4 hours response- ongoing clinical care, level 3 repatriations)

NHS
Critical Care Network
East Midlands

Step 3 Give the following information to Ambulance Control

The Ambulance Call taker will ask for the following information necessary to make the Transport booking:

- Urgency of response
- Current location of Patient – Ward/Unit
- Destination of Patient
- Patient's Name and age
- Patient's condition/medical problem
- Escorts – Number travelling (type – nurse, Consultant, trainee)
- The telephone number/ext. control can call you back on
- Name of person organising transport
- Any other information you feel is relevant

Tell Control the time the ambulance is required at your Unit (consider the time taken to prepare the patient)

Ambulance booking procedure for Bariatric Patients

The Network Transfer trolleys are based on a Ferno Megasus trolley which is bariatric capable up to maximum weight of 232 kg. A bariatric ambulance however with centre mount will be required for the transfer of a critically ill bariatric patient weighing in excess of 232 kg/and/or body shape that cannot be accommodated on the Ferno Megasus trolley with both cot sides extended.

Trolley Securing System in the Ambulance (East Midlands Network only)

All EMAS vehicles are capable of transporting the Network transfer trolley. If an independent transport provider is suggested however, ensure that it has the 3M centre mounting bracket with locking mechanism. (N.B. Not all independent ambulances can accommodate the Network Ferno transfer trolley nor the ParAid transfer trolley).

Further communications with Ambulance Control

Clinical Staff are encouraged to liaise with Ambulance Control should there be any change to the agreed transfer time i.e. if the patient is likely to be ready earlier than originally planned or where there is an anticipated delay due to either the Team not being ready or changes to the patient's condition.

Other considerations

(i) Crew Skill mix

Ambulance Control will routinely supply a non-paramedic crew. The Ambulance irrespective of skill mix will be a front-line A&E equipped vehicle. (Refer to point v.)

(ii) Clinical Escorts

Normally it is expected that only two clinical escorts of the Unit's choice will accompany the patient in the saloon of the vehicle. The one remaining seat will be occupied by the Ambulance person. The reason for this is that the Ambulance Attendant is responsible for health and safety of all persons on the vehicle as well as being present to assist with the preparation and function of Ambulance equipment should the need arise on the journey. In exceptional circumstances, such as where a Unit needs to take an escort for training purposes, this can be requested with Ambulance Control

increasing the number of escorts to a maximum of three, but this must be agreed with Ambulance Control prior to transfer..

(iii) Returning Clinical Escorts

EMAS is responsible for the return of the Critical Care Transfer trolley and equipment and wherever possible will return clinical escorts to the requesting Unit. When returning however, there is always the possibility of the vehicle being diverted to an emergency call as the crew calls clear once the patient has been taken to the receiving hospital, the handover completed, and equipment are returned to the vehicle. In this case the crew and team would attend the incident and possibly convey the patient if space permits. If return of critical care staff to the base unit is time critical then it is advisable for private taxi return transport to be arranged to return staff back to the base hospital.
Please note:

- This should be arranged through switchboard at the referring hospital to ensure staff are covered by appropriate insurance during taxi return journey.
- EMAS will NOT return staff to private provider hospitals after critical care transfer- they will only make a single journey to return the transfer trolley to its NHS base site.

Additional information for Hospital escorts carrying out inter-facility (IFT) critical care transfers

Pre-Transfer

In the event the Ambulance Service is not immediately able to return critical care staff attending a transfer to their base Hospital, staff should not arrange their own taxi transport for insurance reasons. This should be arranged through critical care staff base hospital switchboard using their own Trusts taxi contract- staff are advised to check their local policy for doing this. The Ambulance Service is responsible for returning the critical care transfer trolley but not the accompanying staff.

Post-Transfer

Once the critically ill patient has been taken to the receiving hospital, the handover completed, and staff/equipment are returned to the vehicle, the ambulance crew will call clear. This identifies that the crew and ambulance can respond to life threatening Priority 1 (P1) calls if the closest available resource to a life-threatening emergency. Only P1 calls should be allocated. **If hospital staff experience diversions to non-emergency calls, please notify the Network office ASAP with the ambulance job number of the original IFT booking.**

In the event that hospital staff cannot be returned to their base hospital, staff should return using a taxi as indicated above. The critical care transfer trolley will be returned to the base hospital as quickly as possible but with life threatening calls taking priority there may be a delay in receiving the trolley.

Should the critical care transfer trolley be urgently required for a critical care transfer at the base hospital, Ambulance Control should be contacted to book the same crew/ambulance to carry out this second transfer – like a retrieval service – and the transfer can then be carried out. If the crew have to go off duty, a replacement crew can take over to carry out the transfer.

(iv) **Turnaround at Destination Hospital**

Wherever possible the handover/turnaround cycle should not take more than 30 minutes to ensure that the Ambulance returns to its operational area as soon as practicable. It is accepted that this may be longer to account for a break following a long-distance transfer.

(v) Vehicle Type

This will always be a fully equipped A&E vehicle able to accommodate the MTCCN Transfer trolley and 2 escorting staff.

(vi) Air Ambulance Transfers

Air Ambulance assets within the MTCCN ODN region are tasked by EMAS control and any discussions regarding use of air ambulance transfer should be undertaken via the EMAS Control Centre. Whilst the decision on the clinical appropriateness of consideration of use of an air ambulance asset sits jointly with the air ambulance crew, EMAS and referring clinical teams the final decision to task an Air Ambulance asset sits within EMAS Control and the air ambulance crew.

Use of Air Ambulance assets is very rarely appropriate for planned inter- hospitals critical care transfers and generally, only when transfers are required over very long distances and are time critical where deployment of an air ambulance asset is justified as an inter-hospital transfer vehicle. No additional medical equipment or non-aircrew personnel will be allowed on an air ambulance with a patient and it should be noted that not all air ambulance staff will have the specialist training required for the inter-hospital transfer of complex level 3 critical care patients as their primary clinical role is prehospital emergency care. Only staff with appropriate training and competencies in both critical care AND aero medical transfer should undertake aero-medical critical care transfers.

(vii) Repatriations for non-critical care transfers

Repatriations sit outside the EMAS contract and should either be done as planned extra contractual journeys or booked with a private voluntary provider. However, EMAS holds the Patient Transport Services (PTS) contract in the East Midlands Region for Derby. Nottingham, Nottinghamshire, Lincolnshire are contracted to the independent providers listed below. Burton is serviced by the Patient Transport Service at West Midlands Ambulance Service and by the private ambulance company E-zec medical, contact details as below.

Nottingham/Nottinghamshire - Arriva Transport Solutions (0345 2669662) **Derby/Derbyshire** – EMAS Derbyshire Patient Transport Service (0300 3003434) **Lincolnshire** – TASL (0800 1644586)
Burton – West Midlands Ambulance Service (0138 215555) & E-zec medical (0800 6226199)

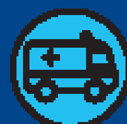
Emergency Ambulance Inter-Facility Transfer (Poster)

Emergency Ambulance Transfers – Inter-facility (IFT)

The process for arranging an emergency ambulance transfer is changing. There are now two levels of emergency response:

IFT level 1 (IFT1)

For exceptional circumstances when you require immediate clinical assistance from the ambulance service, including a declared obstetric emergency, in addition to emergency transport. A response car or motorcycle paramedic may be dispatched in response to an IFT 1 request, to assist in direct patient care. A response will aim to be with you in within seven minutes.



IFT level 2 (IFT2)

Emergency transfer – lights and sirens response. The nearest available emergency ambulance will be dispatched immediately to your department to arrive within 18 minutes (this may mean it being diverted from another emergency call).

Emergency blue light transfers are prioritised on the basis of the treatment or intervention the patient requires or is highly likely to require when they arrive at their destination, not the patient's diagnosis. Examples include, patient going directly to theatre for immediate neurosurgery, primary percutaneous coronary intervention, stroke thrombolysis, surgery for ruptured aortic aneurysm, emergency laparotomy, surgery for ectopic pregnancy, limb or sight saving surgery.

Level one and two interfacility (IFT) transfer requests have been introduced to improve the response that is provided by the ambulance service, and ensure it aligns with the priority given to similar patients who are not at a healthcare facility. However, the clinical staff responsible for the patient should, where possible, make this request; where delegation is unavoidable the individual making the request for support should be in a position to answer triage questions about the patient's condition.

Dial 999

Identify that you are requesting "An emergency interfacility transfer". You will be asked a number of questions (have the answers ready). Wording may differ slightly between services.

Is this request for immediate life-saving clinical assistance from an ambulance service paramedic? If yes, additional questions will be asked to determine if a Level 1 response is necessary.

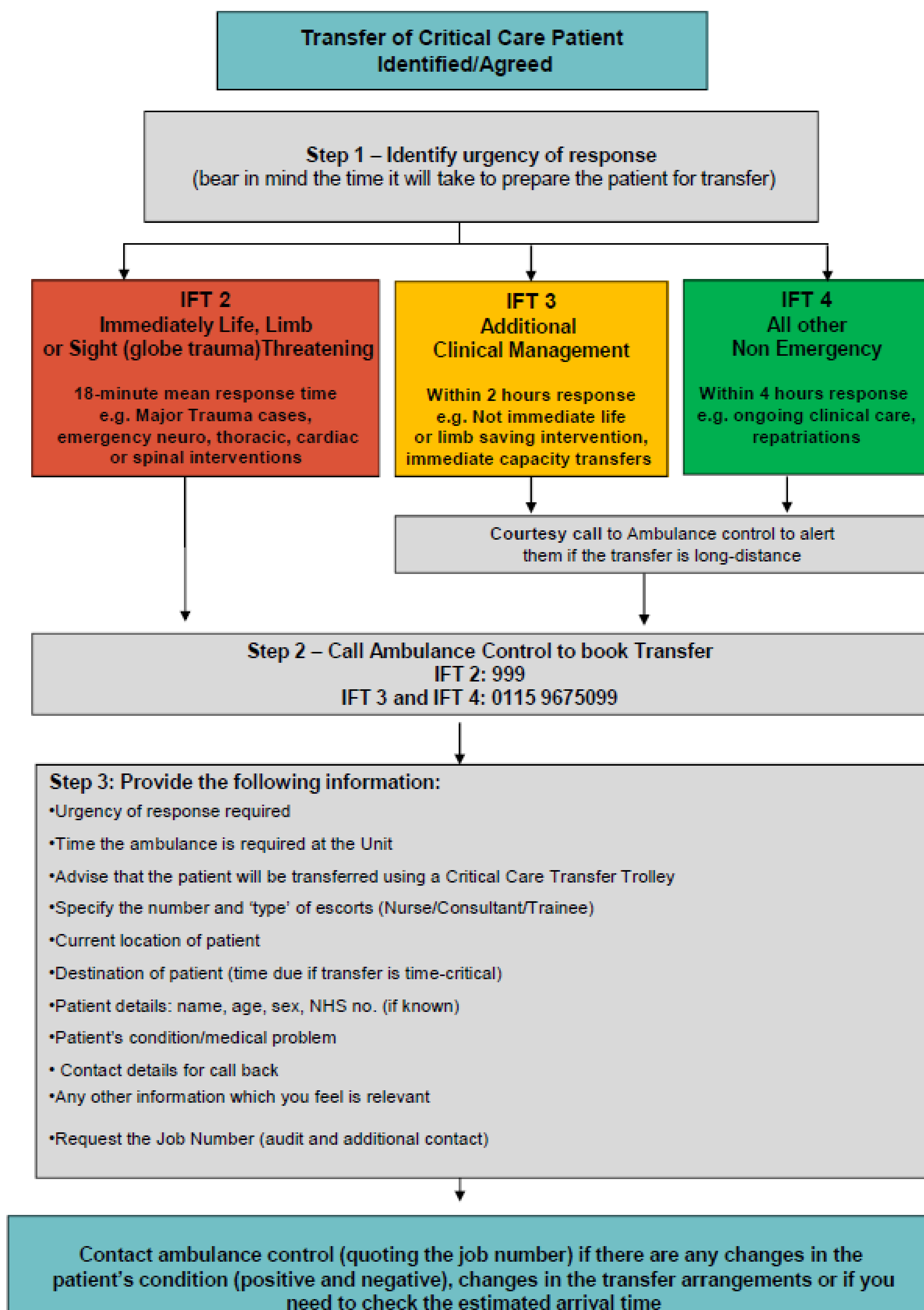
Is this an immediately life, limb or sight threatening situation? If yes, you must explain the reason in terms of the intervention(s) that the patient requires.

All other transfer requests are NOT emergencies, and the response time will depend on how your local ambulance service is commissioned, and how busy the service is at that time.

IFT level 3
Within two hours (if commissioned)

IFT level 4
Within four hours

Appendix G1 - Ambulance Booking Procedure



Appendix H - Legislation Regarding High Visibility Clothing

All staff are expected to wear suitable clothing for transfers and comply with Health and Safety guidance and regulations including the wearing of high visibility clothing when appropriate.