



Midlands Critical Care Networks

Birmingham & Black Country, Central England and North West Midlands Critical Care Networks

Critically Ill Transfer Policy May 2011

1 Introduction:

1.1 This policy relates specifically to the emergency and urgent transfers of all adult critically ill patients level 2 and 3 (appendix A) in the Birmingham and the Black Country (BCCCCN), Central England (CENet) and North West Midlands (NWMCCN) Critical Care Networks. It includes both clinical, non-clinical and repatriation transfers although normally repatriation transfers should be non-urgent.

1.2 This Policy MUST be read in conjunction with local and network transfer guidelines and will be reviewed on an annual basis and updated/amended to meet both clinical and managerial needs as required following Network Board ratification.

1.3 This policy supersedes the earlier policy dated **2nd August 2010** and takes into account the National Ambulance Services Clinical Conveyance Group Inter-Hospital Protocol October 2010 (appendix I).

2 Initiating a Transfer:

2.1 A transfer decision should be made by the critical care consultant or the covering consultant anaesthetist, only if there is absolutely no possibility of an internal placement for the patient. Before initiating any emergency / urgent transfer it is essential to ensure every reasonable attempt to flexibly manipulate the existing critical care beds and staff have been exhausted in accordance with the transfer checklist. (Appendix B). A critical

care patient who does not have a critical care bed should be transferred before a currently admitted patient.

Note:

If the transfer is a time critical issue e.g. intracerebral lesion to a neurosurgical centre, the clinical staff will have to assess the risks involved if the involvement of the Intensivist at the originating hospital will introduce a potential delay. However the Intensivists must be informed as early as possible.

2.2 Emergency/Urgent Critical Care admissions will take priority over all non urgent/elective admissions.

2.3 No critically ill patient will be transferred without first being appropriately assessed by the On-Call Critical Care Consultant for the “transferring” hospital

2.4 Identification of receiving hospital will be in accordance with the Network transfer booking procedure. All units will use the online bed availability system to identify available beds (Appendix C). A unit will not make direct contact with another unit to identify an available bed.

2.5 It is not acceptable for a unit to hold their last critical care bed for potential admissions if a bed is required for transfer of a critical care patient from another unit.

2.6 Every reasonable effort **MUST** be made to stabilise and transfer the “new” patient. If the “new patient” cannot be stabilised then only in exceptional circumstances will the On-Call Critical Care Consultant be required to determine the most appropriate patient for transfer. (*Ref: ICS Guidelines for the Transport of the Critically Ill Adult 2002. point 10.4*)

2.7 No critically ill patient will be transferred without first being adequately resuscitated and stabilised.

2.8 The initial transfer referral agreement will be between the On-Call Critical Care Consultant (transferring hospital) and On-Call Critical Care Consultant (“receiving” hospital). If the transfer is agreed in principle then the relevant “Specialty” on-Call teams at appropriate level or above in both the referring and the receiving hospitals

must then agree the transfer.

2.9 No critically ill patient should be transferred to another hospital without the prior knowledge/consent of the On-Call Critical Care Consultant, the patient's admitting Consultant (or recognised deputy) and Nurse in Charge of Critical Care.

2.10 Transfer of a critical care patient to an AICU (Adult Intensive Care Unit) in another hospital may be required for the following reasons:

<i>Classification of Transfer</i>	<i>Rationale</i>
Clinical	This classification includes all those critically ill patients requiring specialist treatment/care that cannot be provided at the transferring hospital. There is a bona fide, clinical need for transfer that justifies the risk involved
Non-clinical	Having exhausted all other options, the transfer out of a critically ill patient due to the lack of an internal critical care bed or appropriately trained staff. The transfer confers no clinical advantage or benefit to the patient and cannot be justified as being in the patient's best interest.
Repatriation	The relocation of a patient back to their original source hospital for- continuing care nearer to home/carers and/or to provide emergency access to tertiary centres

2.11 All relevant parties, including the relatives, must be fully informed that the transfer is taking place. Where an existing critical care in-patient is to be transferred consent should be obtained from the patient or assent from the next of kin.

2.12 Please refer to appendix C for Ambulance Booking Procedure.

2.13 The ambulance service will assign all transfers to a clinical critical care unit and any transfer of patients with monitors, infusions and/or sedation which cannot be disconnected for the journey priority 2 (within 1hr) as standard practice unless agreed differently between the requesting clinician and ambulance service.
(Appendix I)

2.14 A non clinical transfer will be assigned priority 4 (within 8hrs) unless it is necessary to transfer a patient out in a timely fashion in order to facilitate the unplanned admission of a patient to a critical care area. In these instances patients may be transferred between critical care areas as priority 2 patients.

Planned transfers

3 Mode of Transport:

3.1 The patient is to be transferred in an appropriately equipped vehicle and accompanied by skilled and competent staff (medical staff, critical care nurse, operating department practitioner, paramedic or Accident and Emergency nurse) in accordance with the network transfer guidelines and competence frameworks.

3.2 Longer journeys may require air transport. The decision to move a patient by air should take into consideration all the difficulties currently associated with this mode of transport

4 Accompanying Personnel:

4.1 A critically ill patient should be accompanied by a minimum of two attendants in addition to the transfer vehicle crew. One should be an experienced medical practitioner competent in resuscitation, airway management, ventilation and organ support. The second attendant will usually be a trained critical care nurse. If both medical and nursing staff escorts accompany the patient, a paramedic will not be required, unless specified at the time the request is made.

4.2 All accompanying personnel should be familiar with the patient's clinical condition, the transfer procedure, associated equipment and competent at transferring patients.

4.3 Level 3 999 transfers to the NHS from the independent sector will require Consultant Anaesthetist escort and support from a paramedic if no retrieval team is available or local escort is unavailable.

5 Equipment:

5.1 There should be a dedicated set of equipment available for transfer which should be stored near or on the critical care unit (Appendix D).

5.2 The staff accompanying the patient are responsible for checking the correct functioning of this equipment prior to departure.

5.3 In particular, there should be sufficient battery power in any monitors and infusion pumps. Back-up equipment should be taken on longer journeys.

5.4 A basic box of emergency drugs should also be available. The accompanying doctor should decide what other drugs and fluids, e.g. sedation and inotropes, should be taken in addition.

6 In the Event of a Clinical Incident:

6.1 The normal pattern of transfer will reflect current pathways and unique transfer groups (Appendix E/F/G).

6.2 Occasionally non-clinical transfers of patients out of the transfer groups will occur. It is essential that ALL non-clinical transfers outside the Unique Transfer Groups (UTG) MUST be reported via SITREP's (Appendix H) and each Trust must also implement the process they have in place to inform the following of the transfer by the next working day:

6.2.1 The Trust Chief Executive (or nominated deputy/Executive Director on Call) of the referring hospital

6.2.2 The Network Manager, citing reasons for the transfer. (Reference HSC 2000/17, 2000/16). The Network Manager will then notify-

- a. The host Health Authority Chief Executive
- b. Host PCT Chief Executive.

These communications should not be allowed to delay patient transfer.

7 Preparation for Transfer:

7.1 Meticulous resuscitation and stabilisation of the patient before transfer is the key to avoiding complications during the journey. The transfer personnel should fully familiarise themselves with the patient's history, present condition and treatment up to the point of departure.

7.2 Prior to departure they should make a full clinical assessment to ensure that the patient is ready for transfer.

7.3 Chest drains should be inserted where there is a risk of pneumothorax.

7.4 In addition, the accompanying personnel should ensure that they are adequately prepared for the journey. Suitable clothing should be worn, refreshments must be available for longer journeys, mobile phones and money should be taken in case of emergency. They should also know the precise destination of the patient and have a named contact in the receiving unit.

7.5 The team **must** contact the receiving hospital as they set out for confirmation that a bed is still available at the receiving unit.

8 Monitoring during Transfer:

8.1 During transfer, the standard of monitoring should remain as high as in the Critical Care Unit.

8.2 Non-invasive blood pressure measurement suffers from motion artifact and invasive blood pressure monitoring is preferable.

8.3 End tidal carbon dioxide monitoring should be used in ventilated patients.

8.4 The network transfer form should always be used to record details of the transfer.

9 Inter-Hospital Management:

9.1 Monitoring and therapy should be continuous throughout the transfer.

9.2 Road speed should be governed by the need to reach the destination in the shortest reasonable time and the need for a smooth ride. Hard acceleration and deceleration and a bumpy journey can result in instability in the patient's condition.

9.3 In the event of difficulties or complications the vehicle should be stopped at the first safe opportunity.

10 Repatriation:

10.1 Repatriations can emanate from either a UK hospital, following a clinical or non-clinical transfer, or from overseas, civilian or military. Clinical evidence suggests that it is never in the patient's interest to move a level 3 patient for non-clinical reasons and this should only happen if the patient requests it and all parties are in agreement

10.2 Level 3 patients would not be repatriated unless there is a clinical necessity, including releasing a specialty or military bed. In this scenario it is still necessary to obtain the informed consent of the Level 3 patient (or their advocate) prior to their repatriation.

10.3 Participating organisations will guarantee to prioritise any requests for UK based CLINICAL AND NON-CLINICAL repatriations above and beyond any local demand for elective activity even if this resulted in the cancellation of their elective activity.

10.4 The following principles should govern the process of patient repatriation-

- It is the duty of the all critical care units to retain some degree of ownership of all their non-clinical and clinical transfers. Any request for the repatriation of such patients should be given the highest priority by the local, receiving unit and a bona fide repatriation should take precedence over elective admissions.

- It is the duty of the unit that is seeking to repatriate a previously transferred patient to ensure that the timing of the transfer back is appropriate. Repatriations should always occur during daylight hours and should not be undertaken unless there is a real service need i.e. a significant capacity problem at the repatriating unit.
- As always any request for repatriation should be agreed by the duty critical care consultants at each relevant site and not delegated to trainees. In the event of failure to reach a satisfactory agreement the Lead Clinician at the local receiving hospital should be informed of the situation.

11 Repatriation from Abroad:

11.1 It is the duty of the company repatriating the patient to find an appropriate bed ensuring that a bed is only reserved for the shortest time and that no more than one bed is reserved in the networks for any particular patient.

11.2 It is the responsibility of the transferring team to liaise with the admitting consultants providing up to date information on clinical condition. Once the patient is accepted, transfer of the patient to this unit should occur. On arrival to the unit hand over all relevant medical and personal information

12 Compliance:

12.1 In any matter of clinical or administrative difficulties not covered by this policy or solvable by other means, the Medical Director of the referring hospital shall be asked to settle the issue.

12.2 All critically ill patients **must** be transferred in accordance with this policy. Breach of this policy should be regarded as a critical incident and reported to the Network Manager within 2 working days

12.3 All network critical care units will complete the network transfer documentation as instructed

12.4 All transfer activity will be monitored by the network office and reported to the network's Executive Boards, Operational Board or Clinical Forums.

List of Appendices

- A Definition of Levels of Critical Care
- B West Midlands Critical Care Non Clinical "Transfer Checklist"
- C Bed Identification Flow Chart
- D List of Suggested Transfer Equipment
- E Unique Transfer Group - BBCCCN
- F Unique Transfer Group - CENet
- G Unique Transfer Group - NWMCCN
- H SITREP Definitions and Guidance
- I National Ambulance Services Clinical Conveyance Group, Inter-Hospital Transfer Protocol, October 2010

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Definitions of Levels of Critical Care for Adult Patients

Level 2 Definition-

Patients needing pre operative optimisation

- Cardiovascular, renal or respiratory optimisation required prior to surgery. (Invasive monitoring inserted to assist optimisation (arterial line, and CVP as minimum)).

Patients needing extended postoperative care

- Immediate care following major elective surgery
- Emergency surgery in unstable or high risk patients
- Where there is a risk of postoperative complications or a need for enhanced interventions and monitoring

Patients stepping down to Level 2 care from Level 3

- Requiring a minimum of hourly observations.
- At risk of deterioration and requiring level 3 care again

Patients receiving single organ support

(Exceptions: Basic Respiratory and Basic Cardiovascular Support occurring simultaneously without any other organ support should be considered as Level 2 and Advanced Respiratory Support alone is Level 3)

Patients receiving Basic Respiratory Support

(NB: When Basic Respiratory and Basic Cardiovascular support are provided at the same time during the same critical care spell and no organ support is required, the care is considered to be level 2 care)

Indicated by one or more of the following-

- Mask/hood CPAP or mask/ hood Bi- level positive airway pressure (non invasive ventilation)
- Patients who are intubated to protect the airway but needing no ventilatory support
- CPAP via tracheostomy
- More than 50% oxygen delivered by facemask. (Note, more than 50% has been chosen to identify the more seriously ill patients in a hospital). Short – term increase in FiO₂ to facilitate such as transfers or physiotherapy do not qualify.
- Close observation due to the potential for acute deterioration to the point of needing advanced respiratory support. (e.g. severely compromised airway or deteriorating respiratory muscle function)
- Physiotherapy or suction to clear secretions at least two hourly, whether via tracheostomy, or in the absence of an artificial airway
- Patients who are recently (within 24 hours) extubated after a period (greater than 24 hours) of mechanical ventilations via an endotracheal tube.

NB: the presence of a tracheostomy used for long term airway access only does not qualify for basic respiratory support.

Patients receiving Basic Cardiovascular Support

(NB: When Basic Respiratory and Basic Cardiovascular support are provided at the same time during the same critical care spell and no other organ support is required the care is considered to be level 2 care)

Indicated by one or more of the following-

- Use of a CVP line for monitoring of central venous pressure and/ or provision of central venous access to deliver titrated fluids to treat hypovolaemia
- Use of an arterial line for monitoring the arterial pressure and/or sampling of arterial blood
- Single intravenous vasoactive drug used to support or control arterial pressure, cardiac output or organ perfusion.
- Single/multiple intravenous rhythm controlling drug (s) to support or control

cardiac arrhythmias

Patients receiving Advanced Cardiovascular Support

(NB: Basic Cardiovascular support will frequently occur prior to Advanced Cardiovascular support and should not lead to both Advanced Cardiovascular support and Basic support being recorded on the same calendar day. Advanced Cardiovascular support supersedes Basic Cardiovascular support where this occurs)

Indicated by one or more of the following-

- Multiple intravenous vasoactive and/or rhythm controlling drugs when used simultaneously to support or control arterial pressure, cardiac output or organ/tissue perfusion, (*e.g. inotropes, amiodarone, nitrates*). To qualify for advanced support status, at least one drug needs to be vasoactive
- Continuous observation of cardiac output and derived indices (*e.g. pulmonary artery catheter, lithium dilution, pulse contour analyses, oesophageal Doppler, impedance and conductance methods*)
- Intra aortic balloon pumping and other assist devices
- Insertion of a temporary cardiac pacemaker (criteria valid for each day of therapeutic connection to functioning external pacemaker unit)

Patients Receiving Renal Support

Indicated by one or more of the following-

- Acute renal replacement therapy (*e.g. haemodialysis, haemofiltration etc.*)
or
- Provision of renal replacement therapy to chronic renal failure patient who is requiring other acute organ support in a critical care bed

Patients receiving Neurological Support

Indicated by one or more of the following-

- Central nervous system depression sufficient to prejudice the airway and protective reflexes, excluding that caused by sedation prescribed to facilitate mechanical ventilation or poisoning (e.g. deliberate or accidental overdose, alcohol, drugs ect.)

- Invasive neurological monitoring or treatment e.g. ICP, Jugular bulb sampling, external ventricular drain.
- Continuous intravenous medication to control seizures and/or continuous cerebral monitoring
- Therapeutic hypothermia using cooling protocols or devices

Patients receiving Dermatological support

Indicated by one or more of the following-

- Patients with major skin rashes, exfoliation or burns (e.g. greater than 30% body surface area affected)
- Use of complex dressing (e.g. large skin area greater than 30% of body surface area , open abdomen, vacuum dressing or large trauma such as multiple limb or limb and head dressing)

Level 3 Definition-

Patients receiving Advanced Respiratory Support alone.

(NB: Basic Respiratory support will frequently occur prior to Advanced Respiratory support and should not lead to both advanced Respiratory support and Basic Respiratory support being recorded on the same calendar day. Advanced Respiratory support supersedes Basic respiratory support where this occurs.)

Indicated by one of the following-

- Invasive mechanical ventilatory support applied via a trans-laryngeal tracheal tube or applied via a tracheostomy
- Bi –level positive airway pressure (BIPAP) applied via trans-laryngeal tracheal tube or applied via a tracheostomy
- CPAP via a trans-laryngeal tracheal tube
- Extracorporeal respiratory support

OR

Patients receiving a minimum of 2 organs supported

(NB: Basic Respiratory and Basic Cardiovascular do not count as 2 `

organs if they occur simultaneously (See above under level 2 care)

Examples:

- Basic Respiratory and Neurological support
- Basic Respiratory and Hepatic support
- Basic Respiratory and Renal support
- Basic Cardiovascular and Hepatic support
- Basic Cardiovascular and Renal support
- Advanced Cardiovascular and Renal support
- Advanced Cardiovascular and Hepatic support
- Advanced Cardiovascular and Neurological support

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WEST MIDLANDS CRITICAL CARE NETWORKS

TRANSFER CHECKLIST

April 2011

Patient Name: _____ **Unit Name:** _____ **Date:** _____

- 1. Availability of ICU bed within Hospital explored:**
- | | | | |
|----|--|--------------------------|--------------------|
| a. | Patient's step down to Level 2 or Level 1 facility | <input type="checkbox"/> | Time: _____ |
| b. | Opening up additional Level 3 bed | <input type="checkbox"/> | _____ |
| c. | Short term use of theatre recovery / A&E Resus | <input type="checkbox"/> | _____ |

- 2. Medical decision to ascertain patient's fitness for transfer out:**
- | | | | |
|----|--|--------------------------|-------|
| a. | Appropriately assessed by on call consultant anaesthetist and need for Level 3 care determined | <input type="checkbox"/> | _____ |
| b. | On call Specialty Consultant made aware of need for transfer | <input type="checkbox"/> | _____ |
| c. | Informed Consent obtained from "in-patient" transfer if applicable | <input type="checkbox"/> | _____ |

- 3. Identify available bed:**
- | | | | |
|----|---|--------------------------|-------|
| a. | Identify bed using network's bed availability website | <input type="checkbox"/> | _____ |
| b. | Bed Located: | | |
| | (i) within Unique Transfer Group | <input type="checkbox"/> | _____ |
| | (ii) outside Unique Transfer Group | <input type="checkbox"/> | _____ |

If non clinical transfer is outside Unique Transfer Group notify Chief Executive (or nominated deputy) and Network Manager as per network policy

- 4. Agree transfer with receiving Hospital:**
- | | | | |
|----|---|--------------------------|-------|
| a. | On call CC Consultant Referring Hospital (Name _____) | | |
| b. | On call CC Consultant Receiving Hospital (Name _____) | | |
| c. | Specialty Consultant Referring Hospital (Name _____) | | |
| d. | Specialty Consultant Receiving Hospital (Name _____) | | |
| e. | Nurse in charge informed of potential admission | <input type="checkbox"/> | _____ |
| f. | Middle grade alerted to potential admission | <input type="checkbox"/> | _____ |
| g. | Receiving nurse briefed on expected needs of patient | <input type="checkbox"/> | _____ |

- 5. Pre Transport Checks**
- | | | | |
|----|--|--------------------------|-------|
| a. | Transport team available | <input type="checkbox"/> | _____ |
| b. | Transport coordinated with need for additional investigations | <input type="checkbox"/> | _____ |
| c. | All the notes copied and x-ray/CT hard copies or on disk | <input type="checkbox"/> | _____ |
| d. | There is a transfer bag with spare lines, intubation kit, BVM etc. | <input type="checkbox"/> | _____ |

- e. Transport team have a contact number for own and receiving hospital _____
- f. Infusions have been limited to only the essential ones _____
- g. Team members have taken anti-emetics if needed _____

6. Transport Issues

- a. Airway secure and stable for transport _____
- b. Blood pressure stable for transport _____
- c. Heart rhythm stable for transport _____
- d. Additional medications needed for transport _____
- e. Sufficient batteries for monitor _____

7a. Post Transfer Checks - Airway

- a. Bilateral breath sounds _____
- b. ETT location noted _____
- c. Ventilator settings noted _____
- d. ABG requested _____
- e. CXR requested _____

7b. Post Transfer Checks - Circulation

- a. Blood pressure noted _____
- b. Telemetry noted _____
- c. ECG requested _____
- d. Assessment of access _____

7c. Post Transfer Checks - Others

- a. Initial laboratory orders made _____
- b. Required pharmacological agents ordered _____

8. Family Issues

- a. Patients relatives informed of reasons for transfer _____
- b. Family contact numbers obtained _____
- c. Family discussion about limits of care _____
- d. Family discussion about resuscitation status _____

Completed by: _____

Date: _____ / _____ / _____

Name _____

Signature: _____

Formula for calculating Oxygen requirement in litres-

2 times transport time (in mins) x (minute volume x FiO2{+ driving gas})

Oxygen cylinders DD=460 L, E=680 L, F=1360 L

E.g. 1 hour transfer, 10 l/min MV, 0.6 oxygen and 1l/min driving gas = 2 x 60 x (10 x 0.6 + 1) = 840 litres

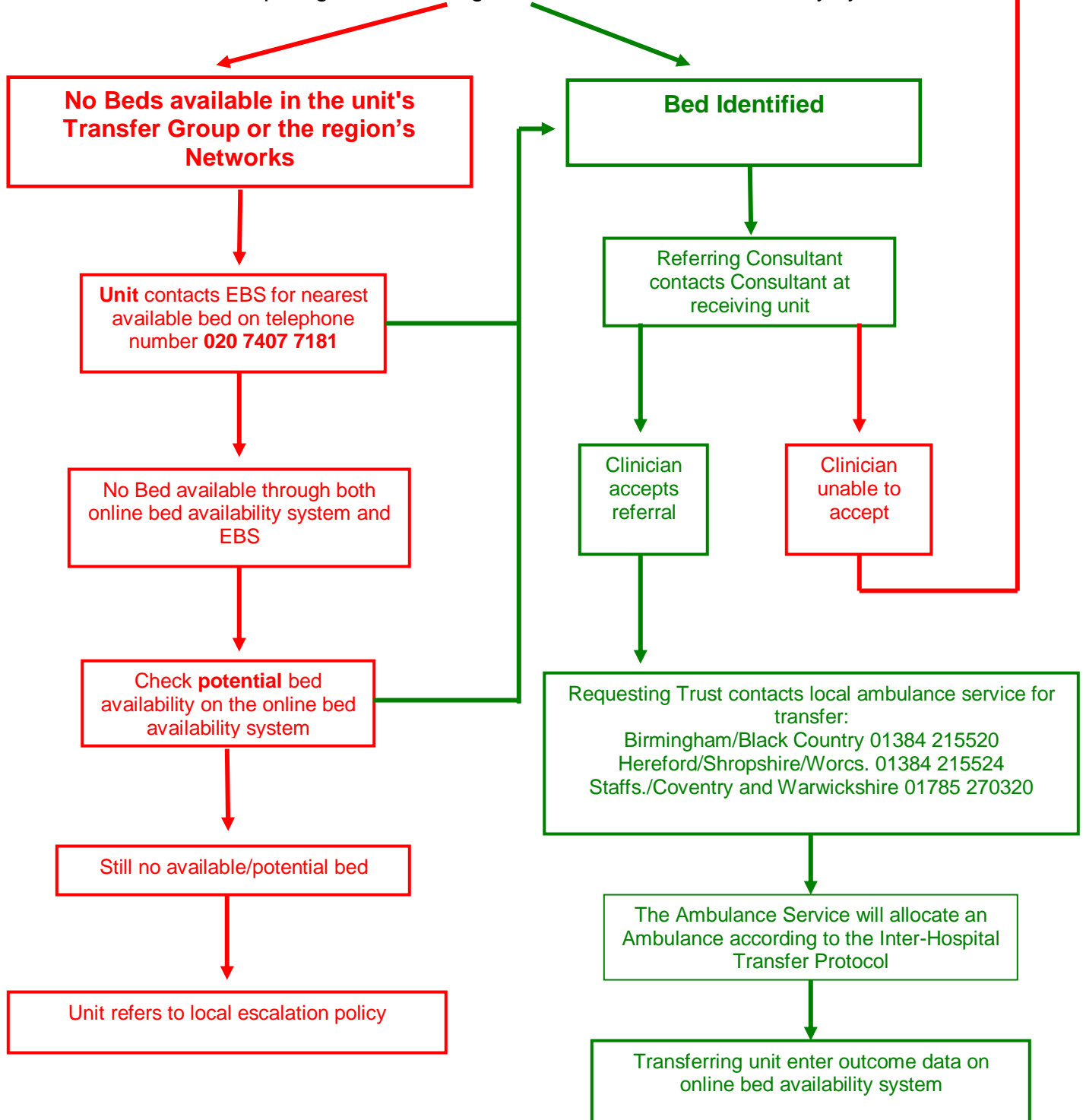
APPENDIX C

The Midlands Critical Care Networks Bed Identification Flow Chart.

All Trusts will enter bed state activity profile twice daily on the online bed availability system at-

www.bedavailability.midlandscriticalcarenetworks.nhs.uk

A Trust requiring a CC bed, logs onto the online bed availability system



Appendix D

List of Suggested Transfer Equipment

Portable ventilator – Fully charged

Full Oxygen cylinder (E or R&D)

Portable monitor - Fully charged plus ambulance mains connection

Portable suction unit

Fully charged syringe drivers plus spare and pump carrier

Pressure bag

Transport rucksack with full contents including intubation, resuscitation and cannulation equipment plus emergency drugs and fluids.

Spare current drug infusions to allow for 3x estimated transfer time (to allow for delays and breakdowns etc)

Transfer documentation – network transfer form

Transport trolley for carriage of medical transfer equipment with suitable anchorage and compatible with ambulance mounting systems.

Appendix E

BBCCCN Unique Transfer Groups

From

To	HEFT - Good Hope	HEFT – BHH/Solihull	Hereford	New Cross	Russells Hall	SW BH	UHB	Walsall Manor	WAH
Abergavenny			✓						
Cheltenham			✓						✓
George Eliot	✓	✓							
Gloucester			✓						✓
HEFT - Good Hope		✓			✓	✓	✓	✓	✓
HEFT - Heartlands/Solihull	✓				✓	✓	✓	✓	✓
Hereford									✓
Mid Staffs								✓	
New Cross					✓	✓		✓	✓
ROH*									
Russells Hall	✓	✓		✓		✓	✓	✓	✓
Shrewsbury				✓					
South Warwick	✓	✓					✓		✓
Stafford				✓					
SWBH - City	✓	✓		✓	✓		✓	✓	✓
SWBH - Sandwell	✓	✓		✓	✓	✓	✓	✓	
Telford				✓				✓	
UHB	✓	✓			✓	✓		✓	✓
UH Cov&Warwick	✓	✓					✓		
Walsall Manor	✓	✓		✓	✓	✓	✓		✓
WAH - Alexandra			✓				✓		✓
WAH – Worcestershire Royal			✓						✓

CENet Unique Transfer Groups

To	From					
	George Eliot	Kettering General	Northampton General	South Warwick	University Hospitals Leicester	University Hospitals Cov. & War.
George Eliot		Yes	Yes	Yes	Yes	Yes
Kettering General	Yes		Yes	Yes	Yes	Yes
Northampton General	Yes	Yes		Yes	Yes	Yes
South Warwick	Yes	Yes	Yes			Yes
University Hospitals Leicester	Yes	Yes	Yes	Yes		Yes
University Hospitals Cov. & War.	Yes	Yes	Yes	Yes		
Heart of England	Yes			Yes	Yes	Yes
Worcs. Acute Hospitals				Yes		Yes
Bedford			Yes			
John Ratcliff			Yes			
Horton (Banbury)			Yes			
Milton Keynes			Yes			
Derby RI					Yes	
NUH (QMC+NCH)					Yes	

Appendix G

**NWMCCN
Unique Transfer Groups**

To	From			
	Mid Staffs General	Robert Jones & Agnes Hunt	Shrewsbury and Telford	University Hospital North Stafford
Mid Staffs General		Yes	Yes	Yes
Robert Jones & Agnes Hunt	Yes		Yes	
Shrewsbury and Telford	Yes	Yes		Yes
University Hospital North Stafford	Yes	Yes	Yes	
Wrexham Maelor Hospital		Yes		
New Cross, Wolv.	Yes			Yes
Leighton				Yes
Queens Burton	Yes			
Walsall Manor	Yes			Yes

SITREP Definitions and Guidance

Situation reports (SITREPs) have been approved by the Department of Health via the Review of Central Returns Steering Committee (ref:ROCR/OR/0067/FT6/010/SITREP).

SITREPs are to be reported via UNIFY2 from NHS trusts actually providing the services, and from Independent Sectors providers.

F4ii) Non-medical critical care transfers out of an approved critical care transfer group during the reporting period

Defined as:

All critical care transfers that take place between hospitals *for non-medical reasons* should be reported. Such transfers between hospitals within the same Trust should be included. Only the trust that is transferring the patient out should report the transfer – the trust receiving the patient does not need to report a transfer on their sitrep. All transfers from specialist hospitals/ units for non-medical reasons (e.g. lack of capacity) also need to be reported.

All non-medical critical care transfers that take place between hospitals not in the same approved transfer group must be reported. These transfers should be regarded as adverse incidents and the NHS Trust from which the transfer took place must ensure that the Chief Executive of the local commissioning body and the host Strategic Health Authority is informed of the transfer within two working days of occurrence.

Repatriation of critical care patients (from one hospital's critical care unit to the critical care unit of the patient's local hospital) should **not** be counted as a "non-medical critical care transfer". In practice however, most repatriations will involve patients who are transferring back to their local hospital for further acute care (i.e. not critical care).

Version: 1.04

Date: 07.09.2010